ParaRegs – Medi-Cal – Scope of Benefits – General and Dental

530-0 – Added 6/21
State law provides that the Department of Health Care Services (DHCS) shall establish a list of covered services, maximum allowable reimbursement rates, and utilization controls. (W&IC 14105.21(c); W&IC 14105.395(a))

DHCS sets criteria for when the agency will approval various medical and dental services. These are set forth in the Provider Manuals and Handbooks. DHCS issues guidance in Policy, All Plan, or Dual Plan letters; the provider manuals represent the most recent criteria, and the manual criteria will apply if different from the guidance. The following links are provided to access these manuals, handbooks and letters:

- DHCS Medi-Cal Provider Manuals
- Medi-Cal Dental Provider Handbook
- Managed Care Plan Guidance Letters

530-1
State law and regulations provide that when prior authorization is required, the Director shall require fully documented medical justification from providers that requested services are medically reasonable and necessary to prevent significant illness, to alleviate severe pain, to protect life or to prevent significant disability. (W&IC 14133.3; 22 CCR 51303)

530-2
Retroactive approval of requests for prior authorization may be granted when a patient does not identify himself to the provider as a Medi-Cal beneficiary by deliberate concealment or because of a physical or mental incapacity to so identify himself. The request for retroactive authorization shall be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month in which the service was rendered. The request for retroactive authorization shall be submitted within 60 days of the certified date of beneficiary identification. (22 CCR 51003(b)(4))

530-3 – Revised 12/08
"Prior authorization," or "authorization" means authorization granted by a designated Medi-Cal consultant or by a Primary Care Case Management (PCCM) plan and is obtained through submission and approval of a TAR. (22 CCR 51003(a))

530-3A – Added 12/08
"Reauthorization" means authorization of a new TAR for continuation of previously authorized Medi-Cal services. (22 CCR 51003(c))

530-3B – Revised 6/21
In addition to indicating the beneficiary identification, provider information, diagnosis and other pertinent information, and the service or item required, the provider submitting a TAR shall explain why the services are medically necessary or submit supporting documentation indicating medical necessity.

A TAR received by the Department from a Fee-For-Service Medi-Cal provider shall be reviewed for medical necessity only.
(22 CCR 51003(b), (d))

530-4 – Revised 1/15
Authorization may be granted only for Medi-Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The Department's "Manual of Criteria for Medi-Cal Authorization" shall be the basis for the professional judgments of Medi-Cal Consultants or PCCM plans in their decisions on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified by the consultant up to a maximum of 180 days, unless otherwise specified. The Medi-Cal consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years.
(22 CCR 51003(e))

530-5
Authorization may be granted only for the lowest cost item or service covered by the Medi-Cal program that meets the beneficiary's medical needs. (22 CCR 51003(f))

530-6
Experimental services are not covered under the Medi-Cal Program. (22 CCR 51303(g))

530-7
Medi-Cal beneficiaries who are eligible for benefits under that program and for the same full or partial benefits under any other State or Federal medical care program or under other contractual or legal entitlements must use those other benefits before using Medi-Cal covered benefits. The requirement does not apply to beneficiaries under Medi-Cal capitated contracting arrangements unless the requirement is contained in the contract. (22 CCR 51005(a))

530-8
When a proposed treatment meets objective criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of five working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of five working days.
(W&IC 14133.9)

531-0 – Added 8/14
Certain adult dental services have been restored effective May 1, 2014. These benefits, subject to utilization controls, are limited to all the following medically necessary services:
- Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.
- Amalgam and composite restorations.
- Stainless steel, resin, and resin window crowns.
- Anterior root canal therapy.
- Complete dentures, including immediate dentures.
- Complete denture adjustments, repairs, and relines.

(W&IC 14131.10(b)(2)(C))

531-1
Full dentures, removable partial dentures that are necessary for the balance of a complete artificial denture, stayplates and reconstructions of removable dentures using standard procedures which exclude precision attachments or implants are covered benefits under the Medi-Cal Program subject to prior authorization. These services are covered only once in a five-year period by the Medi-Cal Program except when necessary to prevent a significant disability or to replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control. (22 CCR 51307(e)(7))
NOTE: 22 CCR 51307 was repealed effective December 2007

531-1A – Revised 6/08
Prior authorization is required for removable prostheses. Precision attachments, implants or other specialized techniques are not a benefit.

Prior authorization shall be considered for a new (i.e., replacement) prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable), General Policies, effective March 1, 2008)

531-1B – Revised 6/08
New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist

The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable) General Policies, effective March 1, 2008)

531-1C – Revised 6/08
A removable prosthesis is a benefit only once in a five-year period. When adequately documented, the following exceptions shall apply:
i. Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or
ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or
iii. The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable), General Policies, effective March 1, 2008)

531-1D – Revised 6/08
The following prosthodontic services are not covered benefits:
- Prosthodontic services provided solely for cosmetic purposes.
- Temporary or interim dentures to be used while a permanent denture is being constructed.
- Spare or backup dentures.
- Partial dentures to replace missing 3rd molars.

Immediate dentures shall be considered when one or more of the following conditions exist:
i. Extensive or rampant caries are exhibited in the radiographs,
ii. Severe periodontal involvement is indicated in the radiographs,

iii. Numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable), General Policies, effective March 1, 2008)

531-1E – Added 6/08

Procedures D5211 and 5212 – Maxillary and Mandibular Partial Denture – Resin Base (including any conventional clasps, rests and teeth)

- Prior authorization is required.
- A benefit once in a five-year period
- A benefit when replacing a permanent anterior tooth/teeth, and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  a) Five posterior permanent teeth are missing, (excluding 3rd molars), or
  b) All four 1st and 2nd permanent molars are missing, or
  c) The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.

Not a benefit for replacing missing 3rd molars.

Note: Procedures D5211 and D5212 do not have to have an opposing full denture.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable), Procedures, effective March 1, 2008)

531-1F – Added 6/08

Procedures D5213 and D5214 – Maxillary and Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)

- Prior authorization is required.
- A benefit once in a five-year period.
- A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  a) Five posterior permanent teeth are missing, (excluding 3rd molars), or
  b) All four 1st and 2nd permanent molars are missing, or
  c) The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.

Not a benefit for replacing missing 3rd molars.

Note: Procedures D5211 and D5212 do not have to have an opposing full denture.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Prosthodontics (Removable), Procedures, effective March 1, 2008)

531-3

Laboratory processed crowns for permanent teeth are a covered benefit subject to prior authorization. (22 CCR 51307(e)(6))

Note: 22 CCR 51307 was repealed effective December 2007.

531-3A – Revised 6/08

The following sets forth Denti-Cal procedures in regard to laboratory processed crowns:

General Policies - Crowns

- Prior authorization is required.
- A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:

i. Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:
   a) The involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,
   b) The loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,
   c) An incisal angle is not involved but more than 50% of the anatomical crown is involved.

ii. Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp. Restorative General Policies (D2000-D2999)

iii. Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

iv. Posterior crowns for patients age 21 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests or for a fixed partial denture which meets current criteria.

- Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
- Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
- Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5-year prognosis for the teeth to be crowned.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Restorative General Policies, Laboratory Processed Crowns)

531-3B – Revised 6/08
Laboratory processed crowns on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy and require prior authorization. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of laboratory processed crowns.

Cast or prefabricated posts are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Restorative General Policies, Laboratory Processed Crowns)

531-3C – Added 6/08
Treatment of dental caries with silver amalgam, silicate cement, acrylic, composite, plastic restorations or stainless-steel crowns, except for incipient or nonactive caries in adults, is a covered benefit.
(22 CCR 51307(b)(8))

Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite. (Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Restorative General Policies, March 1, 2008)

531-5
Removable partial dental prostheses are not a covered benefit under the Medi-Cal Program except when necessary for balance of a complete artificial denture. (22 CCR 51307(d)(4))

531-6 – Revised 6/08
The following sets forth Denti-Cal procedures in regard to periodontics:

- Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.
- Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist).
- Documentation specifying the definitive periodontal diagnosis is required for prior authorization. Current periapical radiographs of the involved areas and arch radiographs are required for periodontal scaling and root planing and osseous surgery for prior authorizations. A panoramic film alone is non- diagnostic for periodontal procedures.
- A current and complete periodontal evaluation chart is required with prior authorizations with the following criteria:
    i. Periodontal evaluation charts are considered current when dated no more than 12 months before the request for prior authorization and when no subsequent periodontal treatment has been performed, and
    ii. At least four pocket depths (two buccal and two lingual), individual tooth mobilities and teeth to be extracted are recorded on the periodontal evaluation chart.

Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have the required pocket depths, a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

i. A full quadrant is considered to have four or more qualifying diseased teeth,
ii. A partial quadrant is considered to have one, two, or three diseased teeth,
iii. Third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Scaling and root planing are a benefit once per quadrant in a 24-month period. Patients shall exhibit a minimum of one 4mm+ pocket, connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Periodontal General Policies, effective March 1, 2008)

531-8
Endodontic therapy; root canal treatment in permanent teeth; recalcification including temporary restoration; Apicoectomy; and Apexification/Apexogenesis; are covered services, subject to prior authorization. (22 CCR 51307(e)(5))

Note: 22 CCR 51307 was repealed effective December 2007.

531-8A – Added 6/08
Prior authorization with current periapical radiographs is required for initial root canal therapy, root canal retreatment, apexification/recalcification and apicoectomy/periradicular surgery on permanent teeth.

Prior authorization for root canal therapy is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.

Root canal therapy is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to nonrestorability or periodontal involvement).

Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Endodontic General Policies, effective March 1, 2008)

531-9
The statute dealing with authorizable dental benefits was amended effective August 15, 1993. Pertinent parts of that revision are set forth below:

1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.
2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:
   A. Periodontal treatment is not a benefit.
   B. Endodontic therapy is not a benefit except for vital pulpotomy.
   C. Laboratory processed crowns are not a benefit.
   D. Removable prosthetics shall be a benefit only for patients as a requirement for employment.
   E. The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

F. The department may approve services for persons with special medical disorders subject to utilization controls, including those set forth above.

(W&IC 14132(h))

531-11 – Revised 6/21

The Medi-Cal Dental Provider Manual contains the complete Manual of Criteria for Medi-Cal authorization (Dental Services).

Orthodontic services for Handicapping Malocclusion are covered as follows:

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (10/05) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- The automatic qualifying conditions are:
  i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request;
  ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request;
  iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate;
  iv. A crossbite of individual anterior teeth causing destruction of soft tissue;
  v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm;
  vi. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Orthodontic General Policies. as revised March 1, 2008)

Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.

(Medi-Cal Dental Provider Handbook, Adjudication Reason Code Description, ARC#199, April 2021, pp. 7-11)

531-11A

Requests for prior authorization for EPSDT supplemental services shall include the following information:

1) The principal diagnosis and significant associated diagnoses.
2) Prognosis.
3) Date of onset of the illness or condition, and etiology, if known.

4) Clinical significance or functional impairment caused by the illness or condition.
5) Specific types of services to be rendered by each discipline associated with the total treatment plan.
6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
7) The extent to which health care services have been previously provided to address the illness or condition and results demonstrated by prior care.
8) Any other documentation available which may assist in making the required determinations.

(22 CCR 51340(d))

531-11B

Orthodontic services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) beneficiaries are covered only when medically necessary pursuant to the criteria set forth in the Medi-Cal "Manual of Criteria for Medi-Cal Authorization", Chapter 8.1, as incorporated by reference in 51003(e), or when medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to criteria in 51340(e)(1) or (e)(3).
(22 CCR 51340.1(a)(2))

531-11C – Revised 6/08

Diagnostic casts are for the evaluation of orthodontic benefits only.

Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. Casts shall be cleaned, treated with an approved EPA disinfectant and dried before being placed in a sealed bag for shipping to the Medi-Cal Dental Program.
(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, effective March 1, 2008)

531-11D – Added 3/21

Orthodontic General Policies

a) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
b) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
c) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
d) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
e) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
f) The automatic qualifying conditions are:
    i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
iv. A crossbite of individual anterior teeth causing destruction of soft tissue,
v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
vi. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

g) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:
   i. When the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or
   ii. When a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available, then current diagnostic casts shall be submitted.

   Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.
h) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.
i) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.
j) If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.
k) If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for re-banding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

(Medi-Cal Dental Provider Handbook; 2021 Manual of Criteria and Schedule of Maximum Allowances, p 5-93-94

531-11G – Revised 6/08
The Department of Health Care Services established regulations implementing the EPSDT program within Medi-Cal. The applicable regulations are 22 CCR 51184, 51242, 51304, 51340, 51340.1, and 51532.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
EPSDT services are the current Denti-Cal Program's scope of benefits for beneficiaries under the age of 21.

The EPSDT program is a special process within Denti-Cal specifically for children. Under federal law, EPSDT services are provided to any Medicaid beneficiary under age 21. For the Denti-Cal Program,

this means medically necessary dental services provided for any Denti-Cal beneficiary who has not yet reached his or her 21st birthday are EPSDT services.

Whenever a Medi-Cal dental provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent treatment resulting from that examination is considered to be an EPSDT dental service – *if* the dental procedure is published in the Medi-Cal Dental Providers Handbook, Manual of Criteria.

EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program. Conversely, the dental service may be part of the Denti-Cal scope of benefits for adults but not for children; or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).

All EPSDT Supplemental Services must be prior authorized and (providers) MUST print "EPSDT Supplemental Services Request" in Field 34 of the TAR/Claim form. If the requested dental service is not listed within the Manual of Criteria, use the appropriate unspecified procedure code and fully describe the service.

At a minimum, (providers) should address the following:

- Diagnosis of the dental condition
- Any overall health issues and medical conditions
- Prognosis with and without the requested treatment
- Clinical rationale for why a covered benefit or lower-cost service will not suffice (you are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale).

Note: Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging). In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR/Claim.

All EPSDT-SS requests for orthodontic services must include a completed Handicapping LabioLingual Deviation (HLD) Index Scoresheet in addition to the aforementioned documentation requirements. The review of active orthodontic services also requires the submission of diagnostic casts.
(Medi-Cal Dental Provider Handbook, Section 9, Special Programs, effective March 1, 2008)

531-11H – Revised 6/08

a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.
c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

(Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Oral and Maxillofacial Surgery General Policies, effective March 1, 2008)

531-11I – Added 7/09
If the patients' orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patients' responsibility to pay for their continued treatment. (Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria, Orthodontic General Policies, as revised March 1, 2008)

531-11J – Added 7/09
Denti-Cal has implemented guidelines to standardize the use of the HLD Index in the orthodontic program.

1) Study models (now known as diagnostic casts) must be of diagnostic quality. To meet diagnostic requirements, study models must be properly poured and adequately trimmed, with no large voids or positive bubbles present. Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.
2) Study models (now known as diagnostic casts) which do not meet the diagnostic requirements described above will not be accepted.
3) Only teeth which have erupted and are visible on the study models should be considered, measured, counted, and recorded.
4) If deciduous teeth are present and the patient is at least 13 years of age, the HLD Index evaluation may be performed.
5) In cases submitted for deep impinging bite with tissue destruction, the lower teeth must be clearly touching the palate, and tissue indentation(s) or other evidence of soft tissue destruction must be visible on the study models.
6) Either of the upper central incisors must be used to measure overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. Do not use the lateral incisors or cuspids for these measurements.
7) The following definitions and instructions will apply when using the HLD Index to identify ectopic eruption:
    a. Examples of ectopic eruption (and ectopic development) of teeth include:
        1. When a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar;
        2. Transposed teeth;
        3. Teeth in the maxillary sinus;
        4. Teeth in the ascending ramus of the mandible; and
        5. Other situations where teeth have developed in locations rather than the dental arches.
    b. In all other situations, teeth deemed to be ectopic must be more than 50 percent blocked out and clearly out of the dental arch.
    c. In cases of mutually blocked-out teeth, only one will be counted.

(Denti-Cal Bulletin, Volume 13, Number 8, May 1997)

531-12 – Revised 6/08
As an expansion of the EPSDT program, the State has developed the Child Health and Disability Prevention (CHDP) treatment mandate, which is a program that provides health assessment screenings to Medi-Cal eligible children from birth to age 19.

The CHDP mandate states that any county receiving funds for uncompensated care "shall provide, or arrange and pay for, medically necessary follow-up treatment, including necessary follow-up dental services and prescription drugs, for any condition detected as part of a CHDP screening for a child eligible for services under the CHDP program." The legislation allows County Medical Services Program (CMSP) counties to contract back with the Department to administer their CHDP treatment mandate/obligation. The Department of Public Health administers this mandate for these counties under the Children's Treatment Program (CTP).

To qualify for CTP services, recipients must be under 19 years of age; must meet CHDP eligibility requirements; and cannot be covered by private health insurance or Medi-Cal with no share of cost, by California Children Services or any other publicly funded program. The CTP allows eligible recipients to be treated by Medi-Cal providers and uses Medi-Cal procedure codes, rates and scope of benefits. Every eligible child and family is informed of the importance of dental services and is offered assistance in receiving services.
(Medi-Cal Dental Provider Handbook, Section 9, Special Programs, effective March 1, 2008)

531-13 – Added 6/08
In accordance with Title 22, Section 51015, of the Title 22 California Code of Regulations (CCR), Denti-Cal has established an appeals procedure to be used by providers with complaints or grievances concerning the processing of Denti-Cal TAR/Claim forms for payment.

First Level appeals should be directed to:
Denti-Cal
Attn: Provider First Level Appeals
P.O. Box 13898
Sacramento, CA 95853-4898
(Medi-Cal Dental Provider Handbook, Section 2, Program Overview)

531-14 – Added 7/09
Pursuant to Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) most adult dental services are eliminated effective July 1, 2009.

Certain adult dental treatments may be completed if all the following requirements are met:
- TARs must be received by Denti-Cal by June 30, 2009;
- The treatment must require prior authorization;
- The treatment must be authorized on a Notice of Authorization;
- The treatment must be completed within the approved authorization period (generally 180 days)
- There will not be any extensions or reevaluations after June 30, 2009.

(Denti-Cal Bulletin, Volume 25, Number 22, May 2009)

531-14A – Added 7/09
The following are exempted from the elimination of adult dental services effective July 1, 2009 and may be authorized:
- Medical and surgical services provided by a Doctor of dental medicine or dental surgery, which if provided by a physician, would be considered physician services;
- Pregnancy related services and services for the treatment of other conditions that might complicate the pregnancy. This includes 60 days of postpartum care.
- Beneficiaries under the EPSDT program;
- With the exception of orthodontic services, beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21;
- Beneficiaries receiving long-term care in an intermediate care facility or a skilled nursing facility. Dental services do not have to be provided in the facility to be payable.
- Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under the FRADS listed in Table 1. A precedent dental service that is not on the list of FRADS will be evaluated and adjudicated on a case by case basis.

(Denti-Cal Bulletin, Volume 25, Number 22, May 2009)

531-14B – Added 7/15
The following adult dental benefits remain in place and do not change as a result of the partial restoration of adult benefits:

Pregnancy related services, emergency services, FRADS, services provided at an Intermediate Care Facility/Skilled Nursing Facility (SNF), and services for Department of Developmental Services consumers.

(Denti-Cal Bulletin, Volume 30, Number 2, May 2014)

531-15 – Added 9/17
The following requirements for EPSDT-SS for Dental Services must be met for the service to be approved:

1) Dental services, other than orthodontic services. Requests for dental services, as EPSDT Supplemental Services, including but not limited to services necessary for the relief of pain and infections, restoration of teeth or maintenance of dental health, shall be evaluated under Section 51340(e)(1) or (e)(3), as applicable.
2) Orthodontic services. Orthodontic services are covered only:
   a) When medically necessary pursuant to the criteria set forth in the Medi-Cal "Manual of Criteria for Medi-Cal Authorization," Chapter 8.1, as incorporated by reference in Section 51003(e) or
   b) When medically necessary for the relief of pain and infections, restoration of teeth, maintenance of dental health, or the treatment of other conditions or defects, pursuant to the criteria set forth in Section 51340(e)(1) or (e)(3), as applicable.

(22 CCR 51340.1(b) (emphasis added))

531-16 – Added 9/17
Whenever a Medi-Cal dental provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. The Department considers any subsequent treatment resulting from that examination to be an EPSDT dental service if the dental procedure is published in the Medi-Cal Dental Providers Handbook, Manual of Criteria.
(Medi-Cal Dental Provider Handbook, Section 9, Special Programs, May 2017, p. 9-16)

531-17 – Added 9/17
EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program. Conversely, the dental service may be part of the Denti-Cal scope of benefits for adults but not for children; or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).
(Medi-Cal Dental Provider Handbook, Section 9, Special Programs, Second Quarter (May 2017), p. 9-16)