State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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DATE: January 28, 2022

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: **APL 22-001: MEDI-CAL DENTAL PROVIDER BILLING PRACTICES**

The purpose of this Dental All Plan Letter (APL) is to remind the Medi-Cal Dental Managed Care (DMC) plans of the Medi-Cal Dental provider billing practices pursuant to Title 22, California Code of Regulations, Section 51002 (a) and Welfare & Institutions Code (W&I Code) Section 14019.4 (a).

BACKGROUND:
Title 22, California Code of Regulations, Section 51002 (a) and Welfare & Institutions Code (W&I Code) Section 14019.4 (a) expressly prohibits a provider from billing a Medi-Cal member for Medi-Cal covered services, including dental scope of benefits. A provider may not bill both the member and the Medi-Cal program for the same dental procedure. Providers may not submit a claim to, or collect reimbursement from a Medi-Cal member or from an authorized representative, except for the specified share of cost a member's eligibility status requires for any service.

POLICY
Current law states that Medi-Cal dentists must ***not***:

1. Arrange for or establish third-party credit or loans for patients administered or under the influence of general anesthesia, conscious sedation, or nitrous oxide. [Business & Professions (B&P) Code § 654.3(g)].

2. Charge to third-party lines of credit (arranged for or established in their office) any treatment costs before the treatments are provided, unless the dentist provides the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs. [B&P Code § 654.3(b)]. The written treatment plan must include:

   a) Each anticipated service to be provided and the estimated cost of each service.
   b) The patient's private or government-estimated share of cost for each service (if applicable, including whether Medi-Cal will cover the service).

c) If services are not covered by patient's private or other insurance (including Medi-Cal), notification that the services may not be covered and that the patient has the right to confirm coverage before starting dental treatment.
d) Written notice must be provided in patient's threshold language. [B&P Code § 654.3(f)].

3. Charge to third-party lines of credit (arranged for or established in their office) any treatment costs more than 30 days before the treatments are rendered (except for orthodontia). [B&P Code § 654.3(c)].

4. Arrange for or establish an open-end credit or loan that contains a deferred interest provision (which is common under many current third-party credit companies). [B&P Code § 654.3(b)].

5. Complete any part of a third-party credit or loan application (arranged for or established in their office) so that any application is not completely filled out by the patient. [B&P Code § 654.3(e)].

6. Arrange for or establish third-party credit or loans when patients are in a treatment area (including but not limited to exam rooms, surgical rooms, and any other area where dental treatment is provided) unless the patient agrees to do so. [B&P Code § 654.3(j)].

Dentists ***must*** provide the patient a written or electronic notice and treatment plan, including an itemized list of treatments and services charged before rendering or incurring costs.

1. The notice must include the revised language specified in B&P Code § 654.3(g).

2. For all Medi-Cal providers, the written treatment plan must indicate if Medi-Cal would cover an alternate medically necessary service. It must also notify the Medi-Cal patient that they have a right to ask for only services covered by Medi-Cal, and that the dentist must follow Medi-Cal rules to secure Medi-Cal-covered services before treatment. [B&P Code §654.3(h)(1)].

Prior to rendering treatment or making arrangements to enter into a private payment agreement with the patient/member, Medi-Cal dental providers must:

- Have a firm understanding of and apply the Current Dental Terminology and Manual of Criteria.
- Understand the Fraud, Abuse and Quality Care section of the Provider Manual.
- Check the member's Medi-Cal eligibility.
- When applicable, offer qualified interpreter to members with limited English proficiency when translating written or oral content free of charge; including sign

language interpreting services. Title 45, Code of Federal Regulations, Part 92.201 (a), requires Medi-Cal providers to provide accurate, timely, and free of charge Language Assistance services to limited English proficiency members.

When Medi-Cal eligibility is verified, the provider may not treat the member as a private-pay member to avoid billing the Medi-Cal program, obtaining prior authorization (when necessary) or complying with any other program requirement. In addition, upon obtaining eligibility verification, the provider cannot bill the member for all or part of the charge of a Medi-Cal covered service except to collect the Medi-Cal copayment or share of cost. Providers cannot bill members for private insurance cost-sharing amounts such as deductibles, co-insurance or copayments.

Prior to recommending or rendering non-covered benefits, providers should first fully explain to the member the treatment options available as covered benefits. Providers should not use administrative or quality of care denials (intentional or unintentional) as reason to conclude that a procedure is a non-covered benefit. Providers should not require members to pay out of pocket for non-covered benefit as a precedent condition to providing covered benefits.

By law, a Medi-Cal provider must reimburse a member for a claim if the member provides proof of eligibility for the time period during which the medically necessary covered service was rendered (and for which the beneficiary paid).

For copies of records and/or radiographs, Medi-Cal providers must charge all patients, including both private and Medi-Cal members, the same fee at a reasonable price. Medi-Cal providers cannot bill a Medi-Cal member for missed or broken appointments.

REQUIREMENTS:

The plans shall provide the following:

1. Evidence that provider networks were notified of the content above.
2. Evidence that provider training materials include the content above.
3. A policy and procedure that ensures plan oversight of provider billing practices.

The plans are to provide the above information within 30 calendar-days from the date of this APL for the review and approval of DHCS to dmcdeliverables@dhcs.ca.gov.

If you have any questions regarding this APL, please direct them to dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Alani Jackson, MPA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services