INITIAL STATEMENT OF REASONS

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments to assist states in furnishing medical assistance to eligible needy persons. California's Medicaid program is called the Medi-Cal program and is administered by the California Department of Health Care Services (Department).

Welfare and Institutions (W&I) Code, sections 10725 and 14124.5 authorize the director of the Department to adopt, amend or repeal regulations as necessary and proper to carry out the purposes and intent of the statutes governing the Medi-Cal program. W&I Code section 14132 sets forth the Medi-Cal schedule of benefits, which includes certain dental services. The Department's Medi-Cal Dental Services Program (Program) is responsible for the delivery of dental services to eligible Medi-Cal beneficiaries. Delta Dental of California (Delta) serves as the fiscal intermediary for the Program, contracting directly with dental providers, authorizing treatments and processing claims.

California State Senate Bill 456 (Chapter 635, Statutes of 2001) added Division 110 (commencing with section 130300) to the Health and Safety (H&S) Code and is known as the Health Insurance Portability and Accountability Act (HIPAA) of 2001. H&S Code section 130301(f) provides that federal HIPAA rules directly apply to state and county departments that provide health coverage, health care, mental health services, and alcohol and drug treatment programs. Additionally, H&S Code section 130301(h) mandates that the implementation of HIPAA shall be accomplished as required by federal law and regulations. H&S Code section 130301(c) further provides that "administrative simplification is a key feature of HIPAA" requiring the development of uniform standards for the coding and transmission of claims. These provisions of the H&S Code subject the Department to federal HIPAA rules and regulations for the implementation of uniform standard code sets.

The federal Health Insurance Portability and Accountability Act of 1996, specifically 45 Code of Federal Regulations §162.1002 adopted as the standard medical data code set, the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA), for dental services. This provision required the Program to update the code set every two years to the national standard Current Dental Terminology procedure codes as compiled by the ADA. The current version of these codes is called CDT 13. These procedure codes are used by the Program, Delta, and dental providers for the identification and billing of dental services provided to Medi-Cal beneficiaries.

W&I Code, section 14133.9 requires the Department to publicize and continue to develop its list of objective medical criteria that guide the professional judgment of Department consultants in their decisions as to whether a service is medically necessary and should be authorized. The Manual of Criteria for Medi-Cal Authorization (MOC), last revised April 11, 2011, which is incorporated by reference in Title 22, California Code of Regulations (CCR), Section 51003, is the method by which the Department has met this requirement. Chapter 8.1 of the MOC available at http://www.dentical.ca.gov/WSI/Publications.jsp?fname=Publications, is dedicated to the dental criteria.

This regulatory proposal supports the intent of the initiating legislation as specified under W&I Code section 14000, which states the purpose of Chapter 7, Basic Health Care is to afford qualifying individuals (such as the aged or disabled) employment of health care services in a manner equitable to the general public and without duplication of benefits available under other federal or state laws.

W&I Code section 14124.5 further specifies that the Director may establish regulations as are necessary or proper to carry out the purpose and intent of this Chapter, which includes outlining the uniform schedule of health care benefits under the Medi-Cal program, as described under section 14131 (including benefits under Article 4 and section 14021 [Mental Health Services]).

The proposed revisions to Title 22, CCR section 51003 and to Chapter 8.1 of the MOC will address the matter of implementing updated national standard CDT 13 codes as mandated by HIPAA, while establishing what health care (dental) services are available under the Medi-Cal program. These amendments will directly benefit dental providers through the provision of dental criteria associated with the national standard CDT procedure codes, which in turn facilitates the delivery of these vital dental services to beneficiaries.

In addition to meeting the goals of the authorizing statutes as described above, these proposed regulation changes assure that the Program meets current standards of dental practice and ensures the proper and efficient administration of the Medi-Cal program in accordance with the federal and state laws that govern the Medi-Cal program's rules of participation, funding and the authorized schedule of benefits.

The following is a detailed discussion explaining the proposed changes to Title 22, CCR and the dental criteria including the justification for each change.

Section 51003 - Amended

Section 51003(e) has been amended to change the revision date for the "Manual of Criteria for Medi-Cal Authorization" from April 11, 2011 to May 1, 2013. This revision of the MOC is specific to the Dental Services Program Chapter 8.1.

Additionally, this MOC revision is due to the change in the updated CDT 13 national standard codes as mandated by the federal Health Insurance and Portability and Accountability Act of 1996 and includes new and revised dental criteria.

MOC Chapter 8.1 – Amended
Chapter 8.1 of the MOC is specifically organized into 12 major dental procedure categories as currently utilized by the ADA and major commercial dental insurers across the nation. These major dental procedure categories include:

- Diagnostic Dental Procedures (D0100-D0999)
- Preventive Dental Procedures (D1000-D1999)
- Restorative Dental Procedures (D2000-D2999)
- Endodontic Dental Procedures (D3000-D3999)
- Periodontal Dental Procedures (D4000-D4999)
- Removable Prosthodontic Dental Procedures (D5000-D5899)
- Maxillofacial Prosthetic Dental Procedures (D5900-D5999)
- Implant Dental Procedures (D6000-D6199)
- Fixed Prosthodontic Dental Procedures (D6200-D6999)
- Oral and Maxillofacial Surgery Dental Procedures (D7000-D7999)
- Orthodontic Dental Procedures (D8000-D8999)
- Adjunctive Dental Procedures (D9000-D9999)

A specific range of CDT procedure codes are included under each major dental procedure category. The general requirements and criteria that apply to each procedure code are described under Chapter 8.1 of the MOC and include the following:

- If the procedure or service requires prior authorization and if so the documentation, radiograph or photograph requirements that must be submitted to the Program for prior authorization,
- The documentation, radiograph or photograph requirements that must be submitted to the Program for payment, and
- If and under what conditions the procedure or service is a covered benefit under the Program.

Diagnostic Procedures (D0100 – D0999)
This category provides a comprehensive explanation of the requirements that apply to diagnostic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Diagnostic dental procedures include examinations, radiographs and photographs. The criteria for diagnostic dental procedures are individually specified in procedure codes D0100-D0999.

Procedure D0190
Screening Of A Patient
This is a new code and is not a benefit.

Procedure D0191
Assessment Of A Patient
This is a new code and is not a benefit.

Procedure D0210
Intraoral- Complete Series Of Radiographic Images
Change in title of procedure deleting “Including Bitewings” and adding “Of Radiographic Images”.

4.c. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

5. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

Procedure D0220
Intraoral- Periapical First Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

2. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

3. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

4. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

Procedure D0230
Intraoral- Periapical Each Additional Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

2. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

3. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

Procedure D0240
Intraoral- Occlusal Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

3. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

Procedure D0250
Extraoral- First Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

Procedure D0260
Extraoral- Each Additional Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

Procedure D0270
Bitewing- Single Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

Procedure D0272
Bitewing- Two Radiographic Images
Change in title of procedure deleting “Films” and adding “Radiographic Images”.

3.a. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

Procedure D0273
Bitewing- Three Radiographic Images
Change in title of procedure deleting “Films” and adding “Radiographic Images”.

The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

Procedure D0274
Bitewing- Four Radiographic Images
Change in title of procedure deleting “Films” and adding “Radiographic Images”.

3.a. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

3.b. A new criterion has been added making this procedure not a benefit for patients under the age of 10. Delta’s pediatric dentist (children’s specialist) recommends this change due to the fact that patients under the age of 10 do not have enough posterior permanent teeth for four bitewing radiographs.

The previous “b.” has become the new “c.”

Procedure D0277
Bitewing- Four Radiographic Images

Change in title of procedure deleting “Films” and adding “Radiographic Images”.

The word “film” has been deleted and “radiographic images” has been added to conform to the procedure title change.

Procedure D0290
Posterior- Anterior Or Lateral Skull And Facial Bone Survey Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

Procedure D0321
Other Temporomandibular Joint Radiographic Images, By Report
Change in title of procedure deleting “Films” and adding “Radiographic Images”.

Procedure D0330
Panoramic Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

3. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change.

4. The words “(including bitewings)” have been deleted and “of radiographic images” has been added to conform to the procedure title change. The word “film” has been deleted and “radiographic image” has been added to conform to the procedure title change.

Procedure D0340
Cephalometric Radiographic Image
Change in title of procedure deleting “Film” and adding “Radiographic Image”.

Procedure D0360
Cone Beam CT- Craniofacial Data Capture
This is a deleted code.

Procedure D0362
Cone Beam- Two Dimensional Image Reconstruction Using Existing Data, Includes Multiple Images
This is a deleted code.

Procedure D0364
Cone Beam CT Capture And Interpretation With Limited Field Of View- Less Than One Whole Jaw
This is a new code and is not a benefit.

Procedure D0365
Cone Beam CT Capture And Interpretation With Field Of View Of One Full Dental Arch- Mandible
This is a new code and is not a benefit.

Procedure D0366
Cone Beam CT Capture And Interpretation With Field Of View Of One Full Dental Arch- Maxilla, With Or Without Cranium
This is a new code and is not a benefit.

Procedure D0367
Cone Beam CT Capture And Interpretation With Field Of View Of Both Jaws With Or Without Cranium
This is a new code and is not a benefit.

Procedure D0368
Cone Beam CT Capture And Interpretation For TMJ Series Including Two Or More Exposures
This is a new code and is not a benefit.

Procedure D0369
Maxillofacial MRI Capture And Interpretation
This is a new code and is not a benefit.

Procedure D0370
Maxillofacial Ultrasound Capture And Interpretation
This is a new code and is not a benefit.

Procedure D0371
Sialoendoscopy Capture And Interpretation
This is a new code and is not a benefit.

Procedure D0380
Cone Beam CT Image Capture With Limited Field Of View- Less Than One Whole Jaw
This is a new code and is not a benefit.

Procedure D0381
Cone Beam CT Image Capture With Field Of View Of One Full Dental Arch- Mandible
This is a new code and is not a benefit.

Procedure D0382
Cone Beam CT Image Capture With Field Of View Of One Full Dental Arch- Maxilla, With Or Without Cranium
This is a new code and is not a benefit.

Procedure D0383
Cone Beam CT Image Capture With Field Of View Of Both Jaws, With Or Without Cranium
This is a new code and is not a benefit.

Procedure D0384
Cone Beam CT Image Capture For TMJ Series Including Two Or More Exposures
This is a new code and is not a benefit.

Procedure D0385
Maxillofacial MRI Image Capture
This is a new code and is not a benefit.

Procedure D0386
Maxillofacial Ultrasound Image Capture
This is a new code and is not a benefit.

Procedure D0391
Interpretation Of Diagnostic Image By A Practitioner Not Associated With Capture Of The Image, Including Report
This is a new code and is not a benefit.

Preventive General Policies (Preventive Procedures D1000-D1999)
These policy amendments were adopted for CDT 13 to specify the general requirements that apply to preventive dental procedures.

1. Dental Prophylaxis and Fluoride Treatment range has been extended to include a new fluoride code D1208.

1. b) Obsolete fluoride codes D1203 and D1204 have been deleted. New fluoride code D1208 has been added.

1. e) Obsolete fluoride code D1203 has been deleted. New fluoride code D1208 has been added.

1. f) Obsolete fluoride code D1204 has been deleted. New fluoride code D1208 has been added.

1.g) Obsolete fluoride codes D1203 and D1204 have been deleted. New fluoride code D1208 has been added. Added “that prevents daily oral hygiene” to be more specific to providers as to what defines a physical limitation and/or oral condition under which the Program may authorize an additional fluoride and/or prophylaxis beyond the stated frequency limitations.

Preventive Procedures (D1000 – D1999)
This category provides a comprehensive explanation of the requirements that apply to preventive dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301**.** Preventive dental procedures include prophylaxis, topical fluoride treatments and space maintenance. The criteria for preventive dental procedures are individually specified in procedure codes D1000-D1999.

Procedure D1203
Topical Application Of Fluoride - Child
This is a deleted code.

Procedure D1204
Topical Application Of Fluoride - Adult
This is a deleted code.

Procedure D1206
Topical Application Of Fluoride Varnish
Change in title of procedure deleting "Therapeutic Application for Moderate to High Caries Risk Patients" and adding "Application Of".

2.a. The obsolete code D1203 has been deleted and the new code D1208 has been added. The word "child" has been deleted as part of the deleted D1203 code (a distinction is no longer made between child and adult fluoride treatments).

2.b. The obsolete code D1204 has been deleted and the new code D1208 has been added. The word "adult" has been deleted as part of the deleted D1204 code (a distinction is no longer made between child and adult fluoride treatments).

Procedure D1208
Topical Application Of Fluoride
This is a new code and is a benefit and mirrors procedure D1206. The only difference is the type of fluoride used, as indicated by the titles for both fluoride procedures.

1. This is a new criterion that is included to inform providers that there are no submission requirements for payment of this procedure to prevent unnecessary submittal of information.

2.a. and b. These are new criteria that are included as a deterrent to dental decay (also known as caries) and for maintenance of good oral health for the patient. The frequency limitations inform providers that a fluoride treatment is only a benefit once in a six-month period for children (under the age of 21) and

once in a 12-month period for adults (age 21 or older) regardless of the other fluoride procedure D1206 because these frequencies are all that would be medically necessary and are for utilization control purposes within the Program.

3. This is a new criterion that specifies that this procedure is a full mouth procedure only so the treatment benefits all of the patient's teeth.

Procedure D1510
Space Maintainer- Fixed- Unilateral
5.c. This is a new criterion added to further explain to providers medical necessity requirements for this procedure. Unilateral space maintainers can only hold the space for one tooth when a deciduous tooth has to be prematurely extracted.

Procedure D1520
Space Maintainer- Removable- Unilateral
5.c. This is a new criterion added to further explain to providers medical necessity requirements for this procedure. Unilateral space maintainers can only hold the space for one tooth when a deciduous tooth has to be prematurely extracted.

Restorative General Policies (Restorative Procedures D2000-D2999)
These policy amendments were adopted for CDT 13 to specify the general requirements that apply to restorative dental procedures.

2. Prefabricated Crowns range has been extended to include a new crown code D2929.

2.A.a) Prefabricated crowns range for primary teeth has been extended to include a new crown code D2929.

3.k) The criterion for considering laboratory processed crowns for prior authorization on teeth that have undergone root canal treatment only after submission of a final root canal radiograph and arch radiographs, has been eliminated. If a tooth needs root canal treatment and a subsequent crown, the provider may submit a single authorization request for both treatments to be approved simultaneously. This proposed change in policy will offer the patient timely treatment because the provider can begin construction of the crown right after the root canal treatment is completed.

l) has been redesignated to k)

Restorative Procedures (D2000 – D2999)
This category provides a comprehensive explanation of the requirements that apply to restorative dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes

as required by H&S Code section 130301. Restorative dental procedures include amalgam restorations, resin-based composite restorations, laboratory processed crowns, cast and prefabricated post and cores and prefabricated crowns. The criteria for restorative dental procedures are individually specified in procedure codes D2000-D2999.

Procedure D2799
Provisional Crown- Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression
Change in title of procedure adding "Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression".

Procedure D2929
Prefabricated Porcelain/Ceramic Crown- Primary Tooth
This is a new code and mirrors the criteria for the procedure D2930. The only difference is that this restoration is tooth colored instead of stainless steel.

1. This new criterion mirrors the criterion for stainless steel crowns (D2930) and does not require prior authorization.

2. This is a new criterion that mirrors criterion for all filling restorative services and has been included in the MOC to establish medical necessity for payment.

3. This is a new criterion to inform providers what is required on the claim for a specific tooth number (code). Primary teeth are numbered "a" through "t".

4. This new criterion mirrors criterion for primary tooth restorations and holds providers responsible for replacement up to a 12 month period after placement.

Procedure D2955
Post Removal
Change in title of procedure deleting "(Not In Conjunction With Endodontic Therapy)".

Procedure D2980
Crown Repair, Necessitated By Restorative Material Failure
Change in title of procedure deleting "By Report" and adding "Necessitated By Restorative Material Failure".

Procedure D2981
Inlay Repair Necessitated By Restorative Material Failure
This is a new code and is not a benefit.

Procedure D2982
Onlay Repair Necessitated By Restorative Material Failure
This is a new code and is not a benefit.

Procedure D2983
Veneer Repair Necessitated By Restorative Material Failure
This is a new code and is not a benefit.

Procedure D2990
Resin Infiltration Of Incipient Smooth Surface Lesions
This is a new code and is not a benefit.

Endodontic Procedures (D3000 – D3999)
This category provides a comprehensive explanation of the requirements that apply to endodontic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H & S Code section 130301. Endodontic dental procedures include pulpotomies, endodontic therapy, endodontic retreatment, apexification/recalcifications and apicoectomies. The criteria for endodontic dental procedures are individually specified in procedure codes D3000-D3999.

Procedure D3351
Apexification/Recalcification/Pulpal Regeneration- Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulp Space Disinfection Etc.)
Non-substantive changes were made to the procedure title to correct prior typographical errors “Pupal” to “Pulpal” and “Pupal” to “Pulp”

Procedure D3352
Apexification/Recalcification/Pulpal Regeneration- Interim Medication Replacement
Change in title of procedure deleting “(Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulp Space Disinfection, Etc.)” and correction of prior typographical error “Pupal” to “Pulpal”.

Periodontal General Policies (Periodontic Procedures D4000-D4999)
These policy amendments were adopted for CDT 13 to specify the general requirements that apply to periodontal dental procedures.

c) The criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis. d) has been redesignated to c).

c), as redesignated. Required radiographs for prior authorization for scale and root planing and osseous surgery has been changed from “arch” to “bitewing”. This change allows the provider to take the minimum required radiographs for these procedures and minimizes x-ray exposure to the patient. The word “film” has been deleted and “radiographic image” has been added to conform to the new title for procedure D0330 Panoramic Radiographic Image.

e) has been redesignated to d)

f)i)ii) These criteria have been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

g) has been redesignated to e)

e), as redesignated. Due to elimination of the criteria in the previous f), the pocket depths from a periodontal chart are no longer necessary.

h) has been redesignated to f)

i) has been redesignated to g)

g), as redesignated. Due to elimination of the criteria in the previous f), the pocket depths from a periodontal chart are no longer necessary.

j) has been designated to h)

h), as redesignated. Due to elimination of the criteria in the previous f), the pocket depths from a periodontal chart are no longer necessary.

k) has been redesignated to i).

l) has been redesignated to j).

m) has been redesignated to k).

n) has been redesignated to l).

o) has been redesignated to m).

Periodontal Procedures (D4000 – D4999)

This category provides a comprehensive explanation of the requirements that apply to periodontal dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13

codes as required by H&S Code section 130301. Periodontal dental procedures include gingivectomy or gingivoplasties, osseous surgeries, and periodontal scaling and root planing. The criteria for periodontal dental procedures are individually specified in procedure codes D4000-D4999.

Procedure D4210
Gingivectomy Or Gingivoplasty- Four Or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

8. has been redesignated to 6.

Procedure D4211
Gingivectomy Or Gingivoplasty- One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

8. has been redesignated to 6.

Procedure D4212
Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth

This is a new code and is not a benefit.

Procedure D4260
Osseous Surgery (Including Flap Entry And Closure)- Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant
2. Required radiographs for prior authorization for osseous surgery has been changed from “arch” to “bitewing”. This change allows the provider to take the minimum required radiographs for these procedures and minimizes x-ray exposure to the patient.

3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

7.b., existing. Due to elimination of the criteria that providers shall submit a periodontal chart, the pocket depths are no longer necessary.

7.c. has been redesignated to 5.b.

Procedure D4261
Osseous Surgery (Including Flap Entry And Closure)- One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant
2. Required radiographs for prior authorization for osseous surgery has been changed from “arch” to “bitewing”. This change allows the provider to take the minimum required radiographs for these procedures and minimizes x-ray exposure to the patient.

3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

7.b. existing. Due to elimination of the criteria that providers shall submit a periodontal chart, the pocket depths are no longer necessary.

7.c. has been redesignated to 5.b.

Procedure D4271
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)
This is a deleted code.

Procedure D4277
Free Soft Tissue Graft Procedure (Including Donor Site Surgery), First Tooth Or Edentulous Tooth Position In Graft
This is a new code and is not a benefit.

Procedure D4278
Free Soft Tissue Graft Procedure (Including Donor Site Surgery), Each Additional Contiguous Tooth Or Edentulous Tooth Position In Same Graft Site
This is a new code and is not a benefit.

Procedure D4341
Periodontal Scaling And Root Planing- Four Or More Teeth Per Quadrant
2. Required radiographs for prior authorization for scale and root planing has been changed from “arch” to “bitewing”. This change allows the provider to take the minimum required radiographs for these procedures and minimizes x-ray exposure to the patient.

3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

7.b. existing. Due to elimination of the criteria that providers shall submit a periodontal chart, the pocket depths are no longer necessary.

7.c. has been redesignated to 5.b.

Procedure D4342
Periodontal Scaling And Root Planing- One to Three Teeth Per Quadrant
2. Required radiographs for prior authorization for scale and root planing has been changed from “arch” to “bitewing”. This change allows the provider to take the minimum required radiographs for these procedures and minimizes x-ray exposure to the patient.

3. This criterion for a definitive periodontal diagnosis has been eliminated for redundancy since the requested procedure code for treatment is the diagnosis.

4. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

5. has been redesignated to 3.

6. has been redesignated to 4.

7. has been redesignated to 5.

7.b. existing. Due to elimination of the criteria that providers shall submit a periodontal chart, the pocket depths are no longer necessary.

7.c. has been redesignated to 5.b.

Procedure D4381
Localized Delivery Of Antimicrobial Agents Via A Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth
Change in title of procedure deleting “, By Report”.

Procedure D4999
Unspecified Periodontal Procedure, By Report
5. The criterion has been eliminated. Requested periodontal treatments are adjudicated using radiographs to determine calculus and bone loss around a tooth. Periodontal chart submission is considered redundant and the charts are no longer used to determine if a periodontal procedure is medically necessary.

6. has been redesignated to 5.

7. has been redesignated to 6.

8. has been redesignated to 7.

Prosthodontics (Removable) General Policies (Prosthodontics (Removable) Procedures D5000-D5899)
These policy amendments were adopted for CDT 13 to specify the general requirements that apply to prosthodontic (removable) dental procedures.

1.a) The requirement for prior authorization for immediate dentures has been eliminated. Immediate dentures are dentures made while the patient still has some teeth and the dentures are delivered to the patient immediately after those remaining teeth are extracted. Since the vast majority of these denture cases are approved, the prior authorization requirement is perceived as a hindrance to the timely replacement of the patient's teeth.

1.c) The word "film" was deleted and "radiographic image" was added to conform to the new title for procedure D0330 Panoramic Radiographic Image.

1.p) The prior authorization requirement was eliminated for immediate dentures as stated in 1.a) above. However, the Department's dental consultants, who have extensive Program adjudication and clinical experience, recommend that the conditions specified under p) are considered for immediate dentures.

Prosthodontic (Removable) Procedures (D5000-5899)
This category provides a comprehensive explanation of the requirements that apply to prosthodontic (removable) dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Prosthodontic (removable) dental procedures include complete dentures, partial dentures, adjustments and repairs to dentures and reline and tissue conditioning to dentures. The criteria for prosthodontics (removable) dental procedures are individually specified in procedure codes D5000-D5899.

Procedure D5130
Immediate Denture- Maxillary
1. The word "not" has been added to remove the prior authorization requirement for immediate dentures (see 1.a) in General Policies above.

2. The criterion for submission of radiographs has been eliminated since prior authorization is no longer required.

3. The criterion for submission of the Justification of Need for Prosthesis (Form DC054) has been eliminated since prior authorization is no longer required.

A new 2. has been added to inform providers that no submission of documents is required for payment for immediate dentures.

4. has been redesignated to 3.

5. has been redesignated to 4.

6. has been redesignated to 5.

7. has been redesignated to 6.

Procedure D5140
Immediate Denture- Mandibular
1. The word “not” has been added to remove the prior authorization requirement for immediate dentures (see 1.a) in General Policies above.

2. The criterion for submission of radiographs has been eliminated since prior authorization is no longer required.

3. The criterion for submission of the Justification of Need for Prosthesis (Form DC054) has been eliminated since prior authorization is no longer required.

A new 2. has been added to inform providers that no submission of documents is required for payment for immediate dentures.

4. has been redesignated to 3.

5. has been redesignated to 4.

6. has been redesignated to 5.

7. has been redesignated to 6.

Implant Service Procedures (D6000 – D6199)
This category provides a comprehensive explanation of the requirements that apply to implant service dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Implant service dental procedures include endosteal, eposteal and transosteal implants, abutments and retainers. The criteria for implant service dental procedures are individually specified in procedure codes D6000-D6199.

Procedure D6051
Interim Abutment
This is a new code and is not a benefit.

Procedure D6056
Prefabricated Abutment, Includes Modification And Placement

Change in title of procedure adding “Modification And”.

Procedure D6057
Custom Fabricated Abutment, Includes Placement
Change in title of procedure adding “Fabricated”.

Procedure D6101
Debridement Of A Periimplant Defect And Surface Cleaning Of Exposed Implant Services, Including Flap Entry And Closure
This is a new code and is not a benefit.

Procedure D6102
Debridement And Osseous Contouring Of A Periimplant Defect; Includes Surface Cleaning Of Exposed Implant Surfaces And Flap Entry And Closure
This is a new code and is not a benefit.

Procedure D6103
Bone Graft For Repair Of Periimplant Defect- Not Including Flap Entry And Closure Or, When Indicated, Placement Of A Barrier Membrane Or Biologic Materials To Aid In Osseous Regeneration
This is a new code and is not a benefit.

Procedure D6104
Bone Graft At Time Of Implant Placement
This is a new code and is not a benefit.

Fixed Prosthodontic Procedures (D6200 – D6999)
This category provides a comprehensive explanation of the requirements that apply to fixed prosthodontic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Fixed prosthodontic dental procedures include pontics, retainers and cast and prefabricated post and cores. The criteria for fixed prosthodontic dental procedures are individually specified in procedure codes D6200-D6999.

Procedure D6253
Provisional Pontic- Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression
Change in title of procedure adding “Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression”.

Procedure D6254
Interim Pontic
This is a deleted code.

Procedure D6793
Provisional Retainer Crown- Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression
Change in title of procedure adding “Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression”.

Procedure D6795
Interim Retainer Crown
This is a deleted code.

Procedure D6970
Post and Core In Addition To Fixed Partial Denture Retainer, Indirectly Fabricated
This is a deleted code.

Procedure D6972
Prefabricated Post And Core In Addition To Fixed Partial Denture Retainer
This is a deleted code.

Procedure D6973
Core Buildup For Retainer, Including Any Pins
This is a deleted code.

Procedure D6975
Coping
Change in title of procedure deleting “Metal”.

Procedure D6976
Each Additional Indirectly Fabricated Post- Same Tooth
This is a deleted code.

Procedure D6977
Each Additional Prefabricated Post- Same Tooth
This is a deleted code.

Procedure D6980
Fixed Partial Denture Repair Necessitated By Restorative Material Failure
Change in title of procedure adding “Necessitated By Restorative Material Failure” and deleting “, By Report”.

Oral and Maxillofacial Surgery General Policies (Oral and Maxillofacial Surgery Procedures D7000-D7999)

These policy amendments were adopted for CDT 13 to specify the general requirements that apply to oral and maxillofacial surgery dental procedures.

1.a)i) The words “that interfere with the alignment of other teeth” were added to more clearly specify the medical necessity requirements for extraction of these teeth.

1.a)v) The words “maligned teeth which cause intermittent pericornitis” were deleted and “extraction of third molars that are causing repeated or chronic pericoronitis” were added to be more specific regarding this criterion. The vast majority of pericoronitis cases are related to third molars (wisdom teeth) and standard of practice indicates that these teeth should be extracted. The correct spelling of “pericoronitis” was also used.

1.a)viii) The words “excluding prophylactic removal of third molars” was added to conform to the criterion as stated in 1.b) and added as a reminder to providers of this criterion that also applies to orthodontically necessary extractions.

Oral and Maxillofacial Surgery Procedures (D7000 – D7999)
This category provides a comprehensive explanation of the requirements that apply to oral and maxillofacial surgery dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Oral and maxillofacial surgery procedures include extractions, alveoloplasties, vestibuloplasties, surgical excision of soft tissue and intra-osseous lesions, excision of bone tissue, treatment of simple and compound fractures, reduction of dislocation and management of temporomandibular joint dysfunctions, suturing of wounds and other repair procedures. The criteria for oral and maxillofacial surgery dental procedures are individually specified in procedure codes D7000-D7999.

Procedure D7260
Oroantral Fistula Closure
1. This is a new criterion requiring that a preoperative radiograph be submitted to verify that the procedure was medically necessary.

1. has been redesignated to 2.

2. has been redesignated to 3.

3. has been redesignated to 4.

4. has been redesignated to 5.

Procedure D7261
Primary Closure Of A Sinus Perforation
1. This is a new criterion requiring that a preoperative radiograph be submitted to verify that the procedure was medically necessary.

1. has been redesignated to 2.

2. has been redesignated to 3.

3. has been redesignated to 4.

Procedure D7610
Maxilla- Open Reduction (Teeth Immobilized, If Present)
1. The word “pre-operative” was deleted and “postoperative” was added. Delta’s board certified oral surgeons have specified that preoperative radiographs do not indicate the degree of the procedure (open or closed) where postoperative radiographs do. This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7620
Maxilla- Closed Reduction (Teeth Immobilized, If Present)
1. The word “pre-operative” was deleted and “postoperative” was added. Delta’s board certified oral surgeons have specified that preoperative radiographs do not indicate the degree of the procedure (open or closed) where postoperative radiographs do. This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7630
Mandible- Open Reduction (Teeth Immobilized, If Present)
1. The word “pre-operative” was deleted and “postoperative” was added. Delta’s board certified oral surgeons have specified that preoperative radiographs do not indicate the degree of the procedure (open or closed) where postoperative radiographs do. This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7640
Mandible- Closed Reduction (Teeth Immobilized, If Present)
1. The word “pre-operative” was deleted and “postoperative” was added. Delta’s board certified oral surgeons have specified that preoperative radiographs do not indicate the degree of the procedure (open or closed) where postoperative radiographs do. This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7650
Malar And/Or Zygomatic Arch- Open Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7660
Malar And/Or Zygomatic Arch- Closed Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7670
Alveolus- Closed Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7671
Alveolus- Open Reduction, May Include Stabilization Of Teeth
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7680
Facial Bones- Complicated Reduction With Fixation And Multiple Surgical Approaches
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7710
Maxilla- Open Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7720
Maxilla- Closed Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7730
Mandible- Open Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7740
Mandible- Closed Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7750
Malar And/Or Zygomatic Arch- Open Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7760
Malar And/Or Zygomatic Arch- Closed Reduction
1. The word “postoperative” was added. Delta’s board certified oral surgeons have specified that postoperative radiographs indicate the degree of the procedure (open or closed). This amendment has been made to ensure submission of the appropriate radiographs for payment.

Procedure D7921
Collection And Application Of Autologous Blood Concentrate Product
This is a new code and is not a benefit.

Procedure D7951
Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach
Change in title of procedure adding “Via A Lateral Open Approach”.

Procedure D7952
Sinus Augmentation With Bone Or Bone Substitutes Via A Vertical Open Approach
This is a new code and is a mirror of the criteria for D7951 with the only distinction being a vertical open approach instead of a lateral open approach (D7951).

1. This is a new criterion requiring prior authorization because this is not considered an emergency procedure and prior authorization is needed for utilization control purposes within the Program.

2. and 3. These are new criteria that are necessary so the Program can verify the need for this procedure based on medical necessity and is based on a recommendation from Delta's staff oral surgeons.

4. This is a new criterion because this procedure is mainly used in conjunction with implant services to augment the sinus to facilitate implant placement.

5. This is a new criterion to verify that the procedure authorized was the procedure performed and is also based on a recommendation from Delta's staff oral surgeons.

Procedure D7960
Frenulectomy- Also Known As Frenectomy Or Frenotomy- Separate Procedure Not Incidental To Another Procedure
4. "a" added due to addition of new criterion "b".

4.b. This is a new criterion added to further explain to providers medical necessity requirements for this procedure. Frenulectomies are only effective and necessary once these permanent teeth have erupted.

Procedure D7963
Frenuloplasty
4. "a" added due to addition of new criterion "b".

4.b. This is a new criterion added to further explain to providers medical necessity requirements for this procedure. Frenuloplasties are only effective and necessary once these permanent teeth have erupted.

Adjunctive General Policies (Adjunctive Procedures D9000-D9999)

These policy amendments were adopted for CDT 13 to specify the general requirements that apply to adjunctive dental procedures.

f)i)-iv) These are new criteria explaining the frequency limitations of different anesthesia procedures and informing providers of the hierarchy of allowed

procedures when one or more types of anesthesia are used on the same date of service. Only one anesthesia type is payable per date of service. These criteria were recommended to the Program by Delta's board certified oral surgeons.

The previous "f)" became the new "g)", "g)" became the new "h)", "h)" became the new "i)" and "i)" became the new "j)".

Adjunctive Service Procedures (D9000 – D9999)

This category provides a comprehensive explanation of the requirements that apply to adjunctive service dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 13 codes as required by H&S Code section 130301. Adjunctive service procedures include palliative (emergency) treatment of dental pain, anesthesia, professional visits and occlusion analysis and treatment. The criteria for adjunctive service dental procedures are individually specified in procedure codes D9000-D9999.

Procedure D9210

Local Anesthesia Not In Conjunction With Operative Or Surgical Procedures

3.b. The words "relieve the patient of pain" were deleted and "eliminate or control a disease or abnormal state" were added to be more specific with providers as to the purpose of this procedure. The purpose of this procedure is not to just eliminate pain but rather to treat a disease or abnormal state such as neuralgias or muscle trismus.

Procedure D9220

Deep Sedation/General Anesthesia- First 30 Minutes

2. The sentence "The anesthetic induction agent shall also be documented." was added. The anesthetic induction agent is the administration of a drug or combination of drugs at the beginning of an anesthetic procedure that results in a state of general anesthesia. The inclusion of this criterion is to distinguish general anesthetic procedures from non-general anesthesia procedures such as intravenous conscious sedation, which does not use an induction agent and to ensure accurate billing by providers.

Procedure D9221

Deep Sedation/General Anesthesia- Each Additional 15 Minutes

2. The sentence "The anesthetic induction agent shall also be documented." was added. The anesthetic induction agent is the administration of a drug or combination of drugs at the beginning of an anesthetic procedure that results in a state of general anesthesia. The inclusion of this criterion is to distinguish general anesthetic procedures from non-general anesthesia procedures such as intravenous conscious sedation, which does not use an induction agent and to ensure accurate billing by providers.

Procedure D9440
Office Visit- After Regularly Scheduled Hours
4.a. was added due to new criterion for 4.b.

4.b. This is a new criterion clarifying that for this procedure to be paid it shall be provided in conjunction with treatment that is a benefit. The purpose of this procedure is to compensate providers for travel time back to their office for after-hours emergencies that are a benefit.

Procedure D9910
Application Of Desensitizing Medicament
4.b. New fluoride varnish code (D1208) has been added and obsolete fluoride codes (D1203 and D1204) have been deleted.

Procedure D9972
External Bleaching- Per Arch- Performed In Office
Change in title of procedure adding “Performed In Office”.

Procedure D9975
External Bleaching For Home Application, Per Arch; Includes Materials And Fabrication Of Custom Trays
This is a new code and is not a benefit.

STATEMENTS OF DETERMINATION

A. ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is proposed, or would be as effective and less burdensome to affected private persons than the proposed action.

B. LOCAL MANDATE DETERMINATION

The Department has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

C. ECONOMIC IMPACT STATEMENT

The Department has made an initial determination that the regulations will not have a significant statewide adverse economic impact directly affecting

businesses including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations will not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

The Medi-Cal program is a voluntary program for both service providers and beneficiaries. These regulations will affect only those dental providers that choose to participate in the Medi-Cal program and the beneficiaries who are offered these dental services through the program.

Additionally, the Department has determined that the regulations will not affect worker safety or the state's environment. However, the regulations will benefit the health and welfare of California residents by maintaining the continuity of the Medi-Cal program through the provision of comprehensive health care services at low cost for low-income individuals such as families with children, seniors, persons with disabilities, children in foster care and pregnant women, including the delivery of dental services.

This regulatory action will benefit Medi-Cal dental providers by updating the MOC with the most current CDT codes, which in turn helps facilitate the delivery of these vital services to beneficiaries.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the regulations may affect small businesses since many Medi-Cal dental providers meet the criteria for a small business. Medi-Cal is a voluntary program for both providers and beneficiaries. Therefore, only those businesses that choose to be Medi-Cal providers for dental services would be affected by these regulations.

E. HOUSING COSTS DETERMINATION

The Department has made the determination that the regulations will have no impact on housing costs.