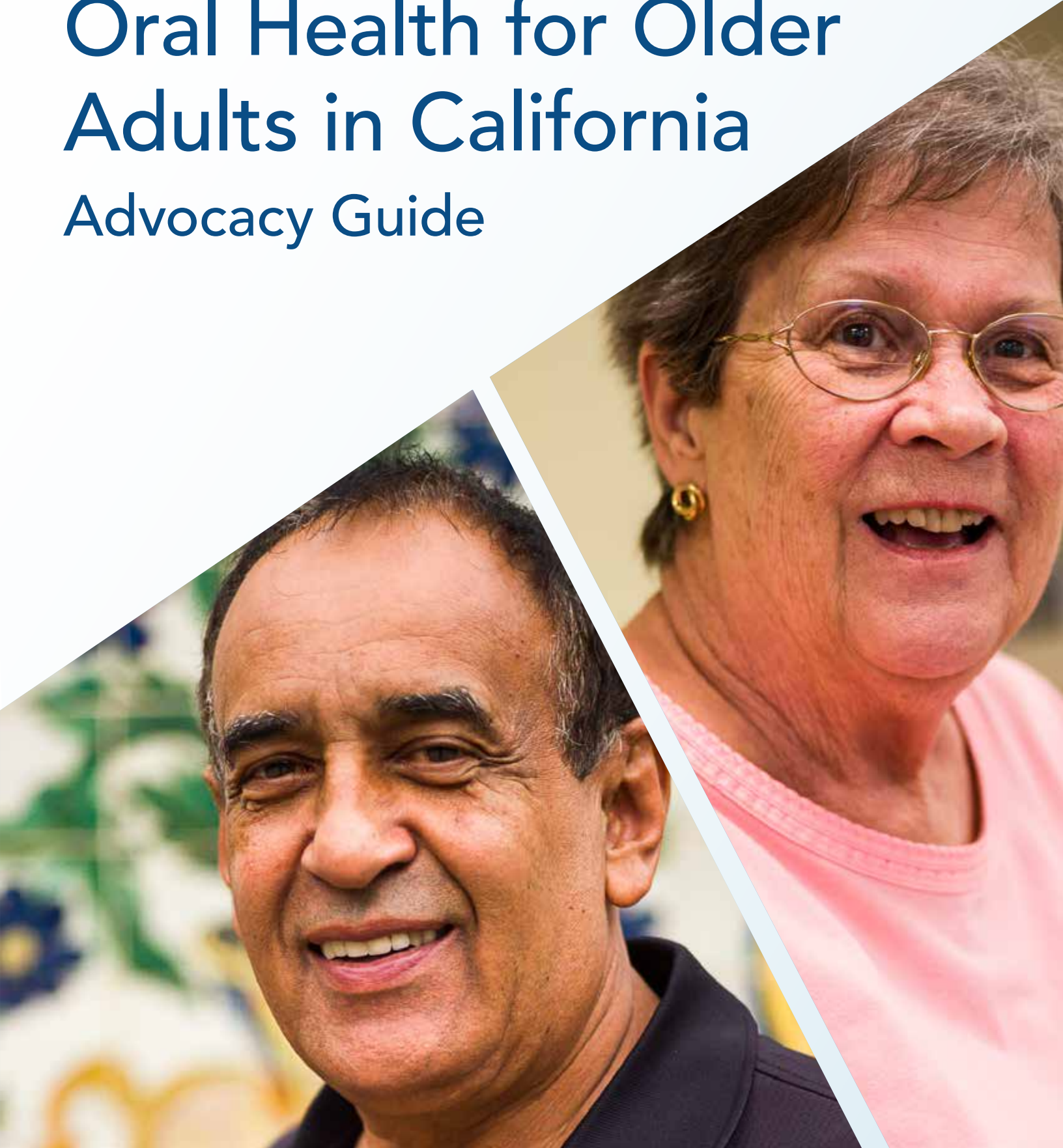


Oral Health for Older Adults in California Advocacy Guide



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About This Guide

This Guide is designed for advocates and individuals—who provide assistance to low-income seniors and persons with disabilities—to better connect their clients to quality dental care. The first portion of this Guide focuses on why oral health matters and provides a summary of the current state of oral health for older adults in California. The second portion of this Guide provides an overview of health insurance coverage options for older adults including a detailed summary of the Denti-Cal program. The third portion of this Guide reviews unique barriers certain sub-populations of older adults encounter including dual eligible beneficiaries (those with both Medicare and Medi-Cal coverage) and individuals residing in institutional settings like nursing homes. The Guide ends with an overview of treatment alternatives for individuals who do not have health insurance. We also have included resources and supplemental materials in the Appendices to assist with advocacy. Justice in Aging strives to make the information in this Guide as accurate as possible as of the publication date (June 19, 2018). However, programs serving this population are always evolving. To get the most up-to-date information on oral health for seniors, sign up for alerts, learn about Justice in Aging webinars, and other trainings, please visit our website, at www.justiceinaging.org/our-work/healthcare/oral-health/ or email Shelby Minister: sminister@justiceinaging.org.

Justice in Aging

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs. Justice in Aging provides technical assistance and advice to advocates, but cannot represent individuals in their claims for benefits.

Acknowledgments

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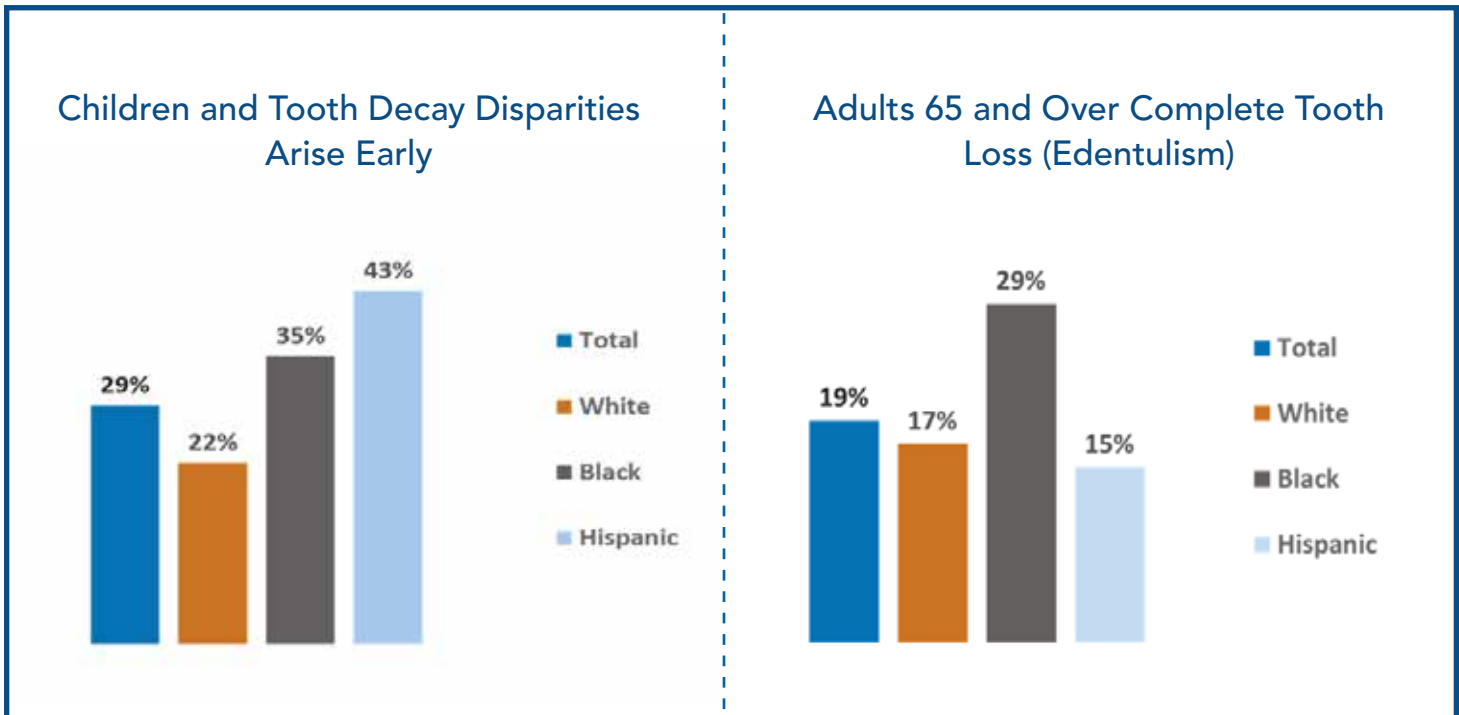
Introduction: Why Oral Health Matters

Oral health is an essential aspect of overall health for people of all ages, but especially for older adults. Unfortunately, older adults in California experience significant challenges when attempting to access oral healthcare.

The State of Oral Health for Older Adults in California

The state of oral health for older adults in California is notably poor. Nearly one third of adults 65 and over have lost six or more permanent teeth, and nearly nine percent of older adults aged 65-74 have complete tooth loss.¹ Tooth loss in nursing facilities is sadly much higher. Over one third of nursing facility residents in California report complete tooth loss and one-third of that group do not have any dentures.² In fact, the oral health of individuals residing in skilled nursing facilities is significantly poorer than those living in the community on all measures including untreated decay, ability to chew, and gum health.³ Similarly, individuals with disabilities, particularly individuals with developmental disabilities, experience poorer oral health and barriers to treatment.⁴

There are troubling disparities based on income level, education, and race/ethnicity that arise early in childhood and carry forward throughout an individual's lifetime. Since untreated oral health decay and disease is progressive, we see childhood disparities persist in adults. Nationally, nearly 62 percent of black adults and 55 percent of Hispanic adults aged 20-64 have lost permanent teeth compared to 49 percent of white individuals of the same age.⁵ And for black individuals 65 and over, 29 percent have complete tooth loss compared to 16 percent of the white individuals. Similarly, 39 percent of older adults who have less than a high school education have complete tooth loss compared to just 13 percent of persons with at least some college.⁶ Higher income older adults on average have two to three more teeth than lower income older adults.⁷ Poor older adults are also twice as likely as those with more income to have a cavity that needs treatment, have untreated root caries, or need periodontal treatment.⁸



A Note on Data

Unfortunately, most of the California-specific data available on the status of oral health for all populations in California is more than ten years old and many measures are not available for older adults age 65 and over. This is an area in need of ongoing advocacy. Most California counties have recently received funding from the Department of Public Health to improve oral health at the local level.⁹ Accordingly, counties have started to draft strategic plans that will include the collection of oral health data. It is important that advocates for older adults engage in the planning process to ensure that the needs of older adults are represented, including the need for data collection specific to older adults. To get engaged, you can contact the Department of Public Health's Oral Health Program: <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram.aspx>.

The Impact of Poor Dental Care on the Health of Older Adults

There is agreement among dental experts that poor oral health has a substantial impact on the general health of older adults. Tooth decay and associated mouth pain lead to weight loss and poor nutrition, and exacerbate chronic conditions like high blood pressure, diabetes and high – conditions that individuals are more likely to acquire later in life.¹⁰ Poor oral health also leads to increased infections, which research associates with higher risk for heart and lung disease, suffering a stroke, and experiencing diabetic complications.¹¹ For older adults with weakened immune systems, oral infections can become chronic.¹²

Poor oral health care also has a significant impact on overall quality of life. Mouth pain disrupts sleep, increasing the likelihood for depression and insomnia. Racial and ethnic minorities, and those living in poverty are also about twice as likely as the general older adult population to report that poor oral health negatively impacts their satisfaction with life.¹³ They report to a greater extent oral pain, food avoidance, and self-consciousness or embarrassment because of their mouth, teeth, or dentures.¹⁴

Oral health and overall health are linked. When the body is healthy, the mouth is more likely to be healthy, too. And, vice versa.

For working age older adults, poor oral health can significantly interfere with both the ability to secure employment and maintain it. A quarter of Californians report that the appearance of their mouth and teeth affect their ability to interview for a job.¹⁵ Nationally, employed adults lose more than 164 million hours of work annually due to dental disease or dental visits.¹⁶

With such significant health, social, and economic impact, the need to address barriers to oral health care is essential. This Guide provides tools for advocates to connect older adults to oral health coverage and care and presents opportunities for advocates to engage in systemic advocacy.

Dental Insurance Coverage for Older Adults

Medicare

This section describes oral health coverage for individuals who have Original Medicare and do not also have Medi-Cal coverage. Please see [p.19](#) below that describes how oral health coverage works for those with Medicare and Medi-Cal, or dual eligible beneficiaries.

Medicare Does Not Cover Dental Care

Medicare is a federal health insurance program that is the primary source of coverage for adults 65 and over and for certain individuals with disabilities. Medicare does not cover all medical needs; most notably for the purposes of this Guide, Medicare does not cover most services “in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.”¹⁷ Accordingly, preventive or restorative dental services will not be covered by Medicare, except in very limited circumstances.

Exceptions

Medicare will cover certain dental or dental-related services in extremely limited circumstances.

Medicare Part A

Medicare Part A will pay for inpatient hospital services in situations in which the individual’s underlying medical condition or the severity of the dental procedure itself requires hospitalization.¹⁸ For instance, patients with certain bleeding disorders or severe cardiac conditions may need to undergo dental surgery in a hospital, where special monitoring and management is available. Part A may cover the hospital services like the facility cost and anesthesia, but not for the dental procedure itself.

Medicare Part B

Dental Services Integral to a Covered Procedure. Medicare Part B will pay for dental services if the dental service is secondary to a primary covered procedure. For example, an individual who needs to have a tooth extraction in order to remove a tumor. As long the teeth are extracted at the **same time** as the tumor removal by the **same physician/dentist**, Medicare Part B will pay for the dental extractions.¹⁹

Medicare Part B will also pay for teeth extractions to prepare the jaw for radiation treatment of neoplastic disease. In this instance, the same time/same dentist requirement does not apply.²⁰

Examinations. Finally, Medicare Part B will pay for a dental examination that takes place inpatient during the workup for an individual who will undergo a renal transplant or heart valve replacement.²¹ While Medicare will pay for the examination, it will not pay for any dental services identified as needed during the examination.

Advocacy Tip (brought to you by the Center for Medicare Advocacy)

Due to the strict limitations of Medicare's dental policy, it can be very difficult to obtain Medicare coverage even for dental services that are incident and integral to a covered medical treatment. The following may improve one's chances of a successful claim or appeal:

1. Proper coding of the beneficiary's diagnoses and procedures;
2. Medical documentation, including a treatment plan, substantiating the need for ancillary dental care; and
3. Supporting statements from physician(s) explaining why the dental services are a necessary part of the patient's primary covered treatment.

One might have a better prospect of prevailing at the third level of appeal, where there is an opportunity for a hearing before an administrative law judge (ALJ) who, by regulation, must give substantial deference to, but is not bound by, the Medicare agency's dental policy. Beneficiaries and their advocates should know, however, that should the ALJ decide to approve their dental claim, the agency may seek to have that decision overturned at the next level of appeal.

Federal Advocacy

Legislative Advocacy

There is a national campaign underway to add dental services to those benefits covered under Medicare. Justice in Aging as well as a number of other national consumer organizations such as Families USA, foundations such as the DentaQuest Foundation, oral health organizations such as Oral Health America, and the American Dental Association, have been engaged in this effort. For more information, visit Oral Health America at <https://oralhealthamerica.org/our-work/advocacy/medicare-dental/>.

CMS Administrative Advocacy

The Center for Medicare Advocacy is working with a broad coalition, including Justice in Aging, to persuade the Centers for Medicare and Medicaid Services to cover the treatment of dental conditions that pose a serious risk to a patient's health or medical care. For more information, visit <http://www.medicareadvocacy.org/medicare-info/dental-coverage-under-medicare/>.

Medicare Advantage Coverage

This section describes oral health coverage for individuals who have chosen a Medicare Advantage plan, and who do not also have Medi-Cal coverage. Please see [p.19](#) below that describes how coverage works for those with Medicare and Medi-Cal, or dual eligible beneficiaries.

Medicare Advantage (MA) plans are managed care plans that provide hospital, outpatient and other health care services to Medicare beneficiaries who have assigned their Medicare benefits to these health plans.

Many Medicare beneficiaries join MA plans in order to reduce their out-of-pocket medical expenses and to obtain benefits not covered by Original Medicare, such as dental care.

Medicare MA plan members must use the plan for all their medical care needs except in certain circumstances such as emergency and urgent care situations. If they use a provider outside the plan's network, including dental providers, without plan authorization, they will have to pay a higher co-payment or, in many cases, the full cost of the service.

MA plans offer dental benefits in a myriad of different ways. Below is a summary of the most common types of MA coverage. If the primary reason an individual wants to join an MA plan is to obtain dental coverage, it is important to carefully compare different plans on coverage and cost.

Example 1

Low Cost, Minimal Benefits

Many MA plans will offer dental coverage for a small monthly premium – for example \$6.00 a month. In return, an individual will pay a small co-pay and receive access to very limited preventive benefits – usually an exam (\$8.00 co-pay) and cleaning (\$5.00 co-pay).

Example 2

Higher Cost, More Benefits

MA plans will also offer more benefits at a higher cost. For example, an individual will pay a monthly premium of \$24.00. Individuals will receive most preventive services for free or have a small co-pay. For restorative services, however, individuals will have to pay a percentage out of pocket. For example, for lower cost procedures like fillings the individual will pay 25% and the plan will pay 75%. For higher cost procedures, like root canals or crowns, the individual will pay 70% and the plan will pay 30%. These MA plan options also generally have a deductible that must be met prior to when the plan starts to pay and will also have an annual maximum benefit the plan will pay towards services, usually around \$1500.

There is a lot of variation among plan offerings. Again, it is very important that individuals carefully review plan options to ensure they are getting the benefits they need for the price they are paying.

Advocacy Tip

The Health Insurance Counseling Assistance Program (HICAP) provides free and objective Medicare counseling. A HICAP counselor can help individuals compare different MA plans and their dental offerings. To reach your local HICAP, call 1-800-434-0222.

Denti-Cal

Medi-Cal Basics

The primary source of dental coverage for low-income older adults in California is through Medi-Cal. The Medi-Cal program is primarily administered by the Department of Health Care Services (DHCS), but the Department of Managed Health Care (DMHC) also has oversight of Medi-Cal health plans. Most older adults and people with disabilities are eligible for Medi-Cal under the aged and disabled program and qualify by having low income and low resources (less than \$2,000). Others may qualify for Medi-Cal

through programs that have different income and resource limits, including Medi-Cal expansion, the 250% working disabled program, and Long Term Care Medi-Cal.²²

There are two primary ways Medi-Cal benefits are delivered:

1. Medi-Cal managed care plans and
2. Fee-for-service

Most populations enrolled in Medi-Cal today receive their Medi-Cal benefits through a Medi-Cal managed care plan. Individuals enrolled in a Medi-Cal plan must see providers contracted with the plan. The plan makes the decision as to what treatment it will authorize for an enrolled member. There are exceptions to mandatory enrollment in a managed care plan, and for the purposes of this Guide, the most notable excluded population is dual eligibles – those individuals with both Medicare and Medi-Cal coverage. Most dual eligibles in the state receive their Medi-Cal benefits through fee-for-service except in County Organized Health System (COHS) counties²³ and in Coordinated Care Initiative counties.²⁴

Individuals enrolled in Medi-Cal fee-for-service can see any provider enrolled in Medi-Cal for all covered services. To receive a covered service, the Medi-Cal provider submits a treatment authorization to the state and the state approves whether a treatment should be authorized.

Dental Benefits in Medi-Cal

Any individual who is eligible for full-scope Medi-Cal is also eligible for dental benefits through Denti-Cal.²⁵ The history of the Medicaid dental benefit in California has been uneven. Except for Federally Required Adult Services (FRADS), adult dental benefits are an optional benefit under the Medicaid program. Accordingly, states do not have to provide dental benefits, and many do not. When states do elect to cover dental benefits, we often see them eliminated when states face a financial downturn. California experienced this in 2009 at which time adult dental benefits were eliminated for adults residing in the community (benefits remained intact for individuals residing in skilled nursing facilities or intermediate care facilities for the developmentally disabled).²⁶ Thankfully, with much advocacy, benefits were partially restored in May 2014 and fully restored in January 2018.²⁷

Below is a summary of the Denti-Cal program including how benefits are delivered, what benefits are covered, limitations in coverage, how benefits are accessed, and Denti-Cal appeals and grievances.

Denti-Cal Delivery System

The delivery system for dental benefits under Medi-Cal is “carved out.” This means that dental benefits are delivered through a system that is separate from the medical benefits. Dental benefits are delivered either through fee-for-service or through a separate dental plan. If an individual is enrolled in a Medi-Cal plan, the Medi-Cal plan is not responsible for delivering the dental benefit. This means that an individual could be enrolled in two plans: one for their Medi-Cal benefits and one for their dental benefits.

Most individuals statewide receive their dental benefits through fee-for-service. This means that an individual can go to any dental provider who is contracted with Denti-Cal. There are two counties, however, that deliver the Denti-Cal benefit through managed care plans. In Sacramento County individuals are required to join a separate Denti-Cal dental plan to access their Denti-Cal benefit. In Los Angeles County, individuals have the option to join a Denti-Cal dental plan or remain in fee-for-service. The three

Denti-Cal plans available in Sacramento and Los Angeles counties are Access Dental Plan, Liberty Dental Plan, and Health Net Dental Plan.

Like Medi-Cal generally, the Department of Health Care Services (DHCS) oversees the Denti-Cal program and contracts with Delta Dental and DXC Technology to carry out functions like processing treatment authorizations, provider applications, and claims processing. With regard to dental managed care plans, both DHCS and the Department of Managed Health Care (DMHC) provide oversight.

What's the difference between Dental Managed Care or Fee-For-Service?

Dental managed care plans are mandatory in Sacramento and voluntary in Los Angeles County.

Dental managed care plans are required to provide the same benefits that individuals receive in fee-for-service. There is no difference in benefit packages. And to date, there has been no real difference in utilization rates between those individuals enrolled in managed care plans versus fee-for-service. In a managed care plan, individuals have to see dental providers contracted with the plan. Managed care plans are required to have an adequate network of providers and meet both time and distance standards, which is not required in fee-for-service to the same degree.

There may be some advantages, however, of enrolling in a Denti-Cal plan. In addition to DHCS oversight, DMHC also oversees Denti-Cal plans. Accordingly, appeals and grievances can also be submitted to DMHC as well as through DHCS. Also, because Denti-Cal plans are required to maintain adequate networks, enrollees can contact the plan to find a provider, whereas in fee-for-service, beneficiaries struggle to find available dentists.

Covered Benefits

The Denti-Cal program benefit package is now fairly comprehensive since benefits were fully restored as of January 1, 2018.²⁸

Denti-Cal now covers most preventive and restorative services including exams, cleanings, fluoride treatment, diagnostic testing (e.g. x-rays), fillings, crowns, root canals on both anterior and posterior teeth, gum treatment, and partial and full dentures.²⁹ Denti-Cal also covers all federally mandated adult services (FRADs). FRADs are dental services that could be performed by a medical doctor (e.g. extractions). These benefits were not eliminated when other optional dental benefits were curtailed in 2009. There are over 140 FRADs.³⁰ As a general rule, Denti-Cal will only pay for the lowest cost procedure that will fix a dental problem.³¹ There are also additional limitations on dental benefits as described below.

The following is a quick reference guide for covered benefits. The details of all covered services, including all covered dental codes and their limitations are spelled out in their entirety in the Denti-Cal Provider Handbook available at www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook/.

Quick Reference Guide for Covered Benefits

Procedure	Full Scope	Residing in a Facility (SNF/ICF)
Initial Exam	Yes	Yes
Periodic Exam	Yes	Yes
Prophylaxis (Cleaning)	Yes	Yes
Fluoride	Yes	Yes
Crowns	Yes	Yes
Laboratory Processed Crowns	Yes (limited circumstances)	Yes (limited circumstances)
Scaling and Root Planing (Gum or Periodontal treatment)	Yes	Yes
Full Mouth Debridement	No	Yes
Periodontal Maintenance	Yes	Yes
Anterior Root Canals	Yes	Yes
Posterior Root Canals	Yes	Yes
Partial Dentures	Yes	Yes
Full Dentures	Yes	Yes
Extractions	Yes	Yes
Emergency Services	Yes	Yes

Limitations

Medically Necessary

All dental services must be deemed medically necessary in order to be reimbursed by Denti-Cal.

Medical necessity refers to the criteria used to decide if covered services are necessary and appropriate for the treatment of the teeth, gums, and supporting structures according to professionally recognized standards of practice.³²

Scope and Type

Almost all dental services covered under Denti-Cal are limited in scope. For example, you can only receive coverage for dentures every five years, one cleaning per year, and a crown every three years. There are narrow exceptions to these limitations. For example, while dentures are only a benefit once in a five-year period, if an individual can document catastrophic loss of the prosthetic beyond the control of the individual (documentation must include a fire or police report); or need for a new prosthesis due to surgical or traumatic loss of the oral-facial structure; or if the denture is no longer serviceable as certified by a dentist, the individual can obtain a new denture sooner.³³

The type of services is also limited. For example, Denti-Cal will not pay for a porcelain crown, but will only reimburse for prefabricated metal and resin crowns. Similarly, Denti-Cal will only pay for lab processed crowns when the treatment is on a tooth that abuts an already existing partial denture.³⁴

Annual Cap

Denti-Cal for adults has an annual cap for benefits of \$1800.³⁵ It is the responsibility of the dental provider to check the cap to ensure it has not been reached prior to rendering services. If the cap has been reached, a provider can seek authorization to exceed the cap as long as the services sought are medically

necessary. There are also major exceptions to what is counted under the cap. FRADS are not included in the cap, nor are dentures, emergency services, and services rendered in a nursing facility.

Again, for a full description of covered benefits and their scope, refer to the Denti-Cal provider handbook.

Accessing Denti-Cal

Finding a Provider

If an individual is in a dental plan in Sacramento or Los Angeles counties, they should contact the plan to find a provider or access the plan's provider directory online. Finding a provider in fee-for-service is a bit more complicated. Denti-Cal has an online directory that allows an individual to access a list of providers organized by county and city. The directory only represents those Denti-Cal providers who have indicated that they are accepting new patients and is not a full list of all Denti-Cal providers. Denti-Cal also offers no guarantee that providers on the list will be available to accept new patients when contacted. Denti-Cal encourages individuals who have a difficult time finding a provider to contact Denti-Cal at **1-800-322-6384**.

Lack of Denti-Cal Providers

There are a number of factors that contribute to California's dearth of Denti-Cal providers. First, the elimination of adult dental benefits in 2009 through 2014 led some providers to leave the Denti-Cal system altogether. Additionally, Denti-Cal providers receive exceedingly low reimbursement rates compared to private insurance. The biggest impediments to participation in the program, however, are the administrative obstacles. The application to become a Denti-Cal provider in 2016 was approximately 40 pages in length and took months to process. Similarly, the treatment authorization and claims process is overly burdensome. With requests for treatment being denied repeatedly combined with low reimbursement rates, many providers decide it is not worth participating in the program.

There has been some progress in addressing these issues. For example, California increased reimbursement rates for targeted services in 2017 and 2018. Denti-Cal also reduced the Denti-Cal provider application to 15 pages and applications are now processed on average within 20 days.

With the full restoration of benefits in January 2018, we hope that some providers who may have avoided the program because of its limited and confusing coverage will decide to enroll. Denti-Cal is also engaging in provider outreach to increase enrollment.³⁶

Despite these advances, however, administrative obstacles in the program persist. Providers report that treatment authorization requirements and claims processing rules are so burdensome that providers do not want to participate in the program at all. And while most of the rules were put in place to address instances of fraud, they now act to impede participation in the program and in some instances induce fraud as providers attempt to circumvent the rules. Ultimately, Medi-Cal recipients are left paying for services that should be free or going without services entirely.

There are certain rural areas of the state that have no Denti-Cal providers accepting patients including for example, Alpine, Amador, Calaveras and Mariposa counties. In these counties and others, call the Denti-Cal Beneficiary line at 1-800-322-6384. Also, listed below are additional oral health treatment options.

Prior Authorization

Most Denti-Cal services require a dental provider to obtain prior approval before rendering services called a treatment authorization request (TAR). In certain cases, x-rays must also be submitted with the TAR. The Provider Handbook sets forth which procedures require prior authorization and what additional documentation is required for services to be rendered.

Notice of Authorization

If a provider submits a treatment authorization, the provider will receive a notice of authorization either approving or denying the authorization. If the authorization is denied, the provider will be informed of the reason why and has the option to submit a request to reevaluate the authorization. A list of adjudication codes can be found in Section Seven of the Provider Handbook.

Notice of Action

The beneficiary should also receive a notice of action (NOA) from Denti-Cal (or from the managed care plan in those counties) when an authorization for treatment is denied or modified. This notice should include a reason for the denial and provide the beneficiary the opportunity to appeal the notice. Included in this Guide in Appendix B are the Reason for Action Codes summarizing the reasons why a claim has been denied. Appeals and grievances are discussed in more detail below.

Advocacy Tip

Individuals should always receive a notice explaining why a service was denied. If an individual has only received notice verbally from their provider, the individual should contact Denti-Cal or their Denti-Cal plan to report that they did not receive a formal notice of action and to request one.

There are reported instances where providers either have not submitted a TAR at all or have not submitted one incorrectly, who then inform the patient that the service has been denied and the individual will have to pay out of pocket. Therefore, it is important to report any instance in which a notice has not been received.

Co-Payments

Standard Medi-Cal co-pays also apply to Denti-Cal. Individuals receiving outpatient care are subject to a \$1.00 co-payment. Non-emergency services provided in an emergency room has a \$5.00 co-pay and prescription drugs have a \$1.00 co-pay. Individuals residing in nursing facilities or other institutions are not subject to co-pays.

It is the provider's responsibility to collect a co-pay at the time of service. Some providers may elect not to collect co-payments. Providers are prohibited from refusing service on the basis that an individual cannot afford a co-payment. However, the individual will remain liable to the provider for payment.³⁷

Share of Cost

Some Medi-Cal recipients are eligible for Medi-Cal with a share of cost. Medi-Cal (or in this case Denti-Cal) will not pay for services until the individual has incurred enough medical (including dental) expenses to meet their monthly share of cost. The dental provider may require the patient to pay their share of cost prior to rendering services.

Transportation

Medi-Cal recipients are entitled to transportation to medical appointments, which include dental appointments, but securing transportation to dental treatment is different based on the type of transportation needed.³⁸

Non-Emergency Medical Transportation

If an individual needs transportation via medical mode of transportation – known as Non-Emergency Medical Transportation (NEMT) – the individual should first try to contact their Medi-Cal plan (if they are enrolled in one) to arrange transportation. While Medi-Cal plans are not required to arrange NEMT to carved out services like dental, some Medi-Cal plans opt to do so. If the Medi-Cal plan will not arrange the NEMT transportation or if the individual is not enrolled in a Medi-Cal plan, the Denti-Cal provider is required to set up NEMT transportation to the appointment. The Denti-Cal provider is responsible for both requesting a treatment authorization request (TAR) for the NEMT and arranging transportation with NEMT fee-for-service providers.³⁹ If the individual is enrolled in a Denti-Cal managed care plan, the plan should help arrange NEMT.

Non-Medical Transportation

If the individual can travel by standard conveyance (e.g. car, bus, etc.) – known as non-medical transportation (NMT) – but has no means of obtaining this type of transportation, the individual's Medi-Cal plan is required to provide NMT to dental services. If the individual is not in a Medi-Cal plan, the individual should contact the county.⁴⁰ Unlike NEMT, the dental provider has no responsibility to arrange NMT. Starting July 1, 2018, Medi-Cal fee-for-service will work with contracted transportation providers to arrange NMT.

Day of Appointment

On the day of an appointment, individuals should bring their Medi-Cal card (aka beneficiary identification card) with them. If the individual is in a dental plan, they should also bring their dental plan card. If an individual needs interpreter services, the dental provider must provide one free of charge. The dental provider also must comply with the Americans with Disabilities Act and is prohibited from discriminating on the basis race, color, national origin, sex, age or disability.⁴¹

If an individual cannot find a dentist that speaks their language they have the right to an interpreter at no charge. Individuals should contact the Denti-Cal telephone service center at 1-800-322-6384 to request an interpreter.

Billing Prohibitions

Denti-Cal providers are prohibited from billing Medi-Cal recipients for any Denti-Cal covered service other than for co-pays and share of cost.⁴² Providers can only charge for non-covered services if the individual understands that it is not a covered benefit and that he or she will be responsible for payment. Denti-Cal providers who violate these rules are subject to sanctions up to three times the Medi-Cal reimbursement rate.⁴³ Denti-Cal providers can also be reported to California Dental Board or sued under the state's Consumer Legal Remedies Act and the Unfair Competition Law for improper billing.⁴⁴

Improper Billing, Upselling, and Dental Credit Cards

Although most basic benefits are now covered under Denti-Cal, providers may attempt to upsell uncovered services that may be better quality (e.g. porcelain crowns) or new treatments not yet covered by Denti-Cal (e.g. Arestin, bone grafts, or Silver Diamine Fluoride). First, providers are prohibited from making a Denti-Cal covered service contingent on receiving an uncovered service. And as stated previously, providers can only charge Denti-Cal recipients for uncovered services if the individual is informed that the services are not covered by Denti-Cal and that the individual will be responsible for payment for those non-covered services. Denti-Cal providers are encouraged to provide this information in writing.⁴⁵

Generally speaking, because Medi-Cal recipients do not have the income or resources to pay for uncovered services, it is advisable that they limit the treatment they obtain to those services covered by Denti-Cal.

However, if an individual having been informed of the above, decides to proceed with the treatment, they will be responsible for the cost. Many providers will offer patients the opportunity to finance the cost of these uncovered services through a dental or care credit card. Medi-Cal recipients should be cautious about entering into these credit arrangements.⁴⁶ Advocates should encourage clients not to feel rushed to enter into the agreement and to read the terms and conditions carefully. Often, these credit cards and similar payment arrangements expose the individual to very high interest rates that can lead to a cycle of debt. Individuals who do not speak English should request that the information be provided to them in a language they understand before signing any documents.

There are additional special protections for dental credit cards. Providers and their staff are required to provide patients with a written notice of credit, written treatment plan, an estimate of costs, and signed acknowledgment that the patient's rights and responsibilities were provided in the appropriate threshold language. These arrangements cannot be entered into if the individual is under the influence of general anesthesia, conscious sedation, or nitrous oxide.⁴⁷ Individuals who speak a language other than English are entitled to receive credit card agreements in their primary language.⁴⁸ If the provider fails to comply with these requirements, the individual is entitled to relief pursuant to the Consumer Legal Remedies Act and Unfair Competition Law.⁴⁹

If your client has entered into a dental or care credit arrangement, it is advisable that they obtain legal representation. The Health Consumer Alliance has trained legal services attorneys on this topic who are equipped to assist with these types of cases. See Appendix A for contact information.

What's the difference between an appeal and grievance?

An **appeal** is a formal way of asking Denti-Cal or a Denti-Cal plan to change a decision regarding coverage.

A **grievance** is any complaint other than one for a coverage decision.

Appeals and Grievances

Appeals

Dental Fee-for-Service

The Denti-Cal appeals process is the same as it is for Medi-Cal generally. Most major dental services require the provider to submit a treatment authorization request (TAR) prior to rendering services. In instances where the TAR is denied, both the individual and the provider should receive a notice informing them of the denial and the reason for the denial (See Appendix B for denial codes and reasons). Since most Denti-Cal recipients are in fee-for-service, they have a right to request a state fair hearing as soon as they receive a notice of action denying a service. The hearing must be requested within 90 days of the date of the notice. There are certain Denti-Cal services that do not require a TAR like dental exams, cleanings, and fluoride treatments. If an individual receives a bill for these services, they should contact Denti-Cal since providers are prohibited from billing for covered services.

Dental Managed Care

Individuals enrolled in a dental plan have a different appeals process.⁵⁰ After receiving a denial notice, the individual must first file an appeal with the dental plan. If the dental plan denies the appeal, the individual can request a state fair hearing or continue with the plan appeals process by requesting an internal medical review (IMR) or do both. For example, if an individual asks for an IMR first, but does not agree with the decision, they can still ask for a State Hearing later. However, if the individual asks for a State Hearing first, and the hearing has already taken place, the individual cannot ask for an IMR. In this case, the State Hearing has the final say.

Grievances

It is important to file a complaint or grievance with Denti-Cal or the Denti-Cal plan any time an individual experiences a problem with the Denti-Cal program. This ensures that the Denti-Cal program is made aware of issues individuals face in the program and the program remains accountable to address these issues. Grievances should be filed in instances where an appeal has been filed if the issue goes beyond just a standard denial of coverage, and also in instances where an individual has to wait long periods for an appointment, received poor care, was treated rudely, was not provided language assistance, or was improperly billed.

Dental Fee-For-Service

An individual can file a grievance by contacting the Denti-Cal Telephone Service Center at 1-800-322-6384. The complaint can be taken over the phone. The individual can also file a complaint by filling out a complaint form available at https://www.denti-cal.ca.gov/DC_documents/beneficiaries/bene_complaint_form.pdf and mailing it to Denti-Cal. Denti-Cal must acknowledge receipt of the grievance within five (5) days of receiving the complaint and must make a conclusion within 30 days. If the individual is not satisfied with the conclusion, they can request a state fair hearing.

Dental Managed Care

If the individual is in a dental managed care plan, the grievance should be filed with the plan. It is important to ask the plan to formally take a grievance. While some issues can be resolved quickly, it is

problematic when plans do not formally accept and respond to a grievance since there is no record of the incident. We therefore recommend that advocates insist that plans record the grievance.

Integration and Denti-Cal

As mentioned previously, Denti-Cal is a carved out benefit and is not integrated with the delivery of medical care. Medical doctors are unlikely to examine an individual's mouth, and likewise, dental providers do not always consider the individual's medical condition in treating their oral health issues. For example, older adults often take multiple medications, many of which cause dry mouth and exacerbate oral health issues. Similarly, diabetes increases the risk of infections forming in the mouth, so the need for regular gum treatment is very important. In an ideal integrated world, we would see medical providers connecting their patients with diabetes to oral health providers.

There have been efforts to help to improve integration and advocates are working to better integrate dental care into overall medical care. For example, Assembly Bill 2207 requires Medi-Cal plans to include a dental screening in the health risk assessment they must conduct for each enrollee. Plans are required to ensure that enrollees are referred to a dental provider and identify plan liaisons that work with Denti-Cal fee-for-service and plan providers to assist with referrals.⁵¹ Unfortunately, most plans are not following these rules and the Department of Health Care Services has not enforced them. Advocates must continue to push DHCS and the plans to comply with these rules. We also must continue to talk about how oral health is critical to maintain overall health and advocate for initiatives that better integrate oral health into the delivery of medical care.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to older adults who meet the following eligibility criteria: individuals must live in the PACE service area, be 55 or over, meet a nursing facility level of care, and be able to safely live in the community.⁵² PACE plans provide all Medicare and Medi-Cal covered services, including covered dental services, at a PACE site. If the PACE site is unable to perform a covered dental service at the site, the individual will be referred to a community provider.

Commercial Plans & Dental Savings Plans

Commercial Plans

Older adults who are not eligible for Medi-Cal and who have the financial means may want to consider purchasing a commercial plan. There are common features with these plans that individuals should compare when shopping for coverage. These plans will include costs for monthly premiums and an annual deductible that must be met before the plan will pay for coverage. Plans almost always will also have a low annual benefit maximum (e.g. \$1,000). Another common feature is a waiting period: individuals have to be enrolled in the plan for six months, for example, before being eligible to receive most covered services. Most services will not be covered at 100%. Instead, the individual will be responsible for coinsurance or the plan will offer a discount on major services (e.g. 25% discount on services by in-network providers).

Dental Savings Plans

Dental Savings Plans are not really plans at all in the traditional sense. Rather, an individual pays an annual fee and then receives discounts from providers who have agreed to accept the plan. The discounts vary depending on the service sought. For example, an individual could receive a 60% discount on an annual exam and a 40% discount on a crown. Unlike a commercial plan, these savings plans typically do not have annual benefit maximums or waiting periods. Again, it is important for individuals to compare plans for cost, benefits, and access to providers.

Advocacy Tip

There have been reports that some dental savings plans are not all they claim to be. Advocates report that after enrollment, individuals learn of hidden fees or that many of the providers who are listed do not in fact participate in the discount program. Individuals should carefully review the fine print of these plans and look into whether the providers listed are participating in the program. Advocates should report any instances of fraudulent discount cards to the Department of Managed Health Care, the Better Business Bureau, and the Consumer Financial Protection Bureau.

Special Populations

Dual Eligibles

Dual eligible beneficiaries – those individuals who have both Medicare and Medi-Cal coverage – often experience unique barriers to accessing care because of their dual status. The primary barriers duals face in accessing oral health care occur when they opt to enroll in a Medicare product that offers dental coverage. They may encounter difficulties because of how that Medicare coverage interacts with their Denti-Cal coverage. Below is a summary of how coverage should work.

Medicare Advantage or Other Dental Coverage + Denti-Cal

Medi-Cal is always the payer of last resort. This means that for a dual eligible individual who has enrolled in either a Medicare product with dental or other standalone dental plan (hereinafter referred to as Medicare plan for simplicity), the Medicare coverage is primary. Accordingly, a dual must see a dental provider that is contracted with his Medicare plan. This often leads to dual eligibles being improperly billed for services covered by Denti-Cal. Here are some examples of what we see happen:

Example 1

A dual eligible individual seeks treatment with a provider contracted with her Medicare plan for a root canal on the back tooth. The Medicare plan will only pay 30% of the root canal. Yet, Denti-Cal will fully cover a root canal. The Medicare provider, however, is neither contracted with Denti-Cal as a provider nor familiar with how to bill Medi-Cal, nor aware that he is prohibited from billing a dual for services covered by Denti-Cal. Accordingly, the dual eligible is billed for 70%.

This is illegal billing of a dual eligible. The Medicare provider is prohibited from billing a dual eligible for a Medi-Cal covered service pursuant to state law (and in certain circumstances federal law).⁵³ Instead, the

provider should submit a crossover claim to Medi-Cal. Medi-Cal will pay the provider up to the Medi-Cal approved amount. This might be less than what the provider would receive under Medicare. The provider, however, must accept the Medi-Cal payment as payment in full. The provider is prohibited from billing the dual eligible for the remaining balance.

Medicare providers do not have to enroll in Medi-Cal to bill Medi-Cal. Providers simply have to complete a one page form that allows them to submit claims to Medi-Cal after Medicare has paid. The form is available here: https://www.denti-cal.ca.gov/DC_documents/providers/MC%200804%20Crossover%20application.pdf.

Advocacy Tip

If a dual eligible is billed for a Medi-Cal covered service, it should raise a red flag. Most likely, with few exceptions, the billing is improper. Justice in Aging has a toolkit on improper billing of dual eligibles that includes fact sheets, sample letters to send to providers, and other resources. The toolkit is available here: <http://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/>.

Example 2

The dual eligible goes to a Denti-Cal provider to receive treatment. The provider is not contracted with the dual's Medicare plan. The Denti-Cal provider may refuse to treat the dual eligible since the provider likely will not be paid from the Medicare plan since the provider is out of network. If the provider does decide to provide services, the dual eligible cannot be billed for Denti-Cal covered services pursuant to state law. However, to avoid being billed, it is advisable that dual eligibles who have Medicare dental coverage seek treatment with a dental provider who is contracted with the Medicare plan and explain to the Medicare provider that they also have Denti-Cal coverage and should not be charged for services covered by Denti-Cal. The Medicare plan provider cannot refuse to see a dual because they have Denti-Cal coverage.⁵⁴

Advocacy Tip

Since Denti-Cal now offers fairly comprehensive dental coverage for free, it is important for dual eligibles to evaluate whether it makes sense to be enrolled in a Medicare product that offers dental – especially if a primary reason for enrolling in the Medicare product is to obtain dental coverage. The individual should evaluate whether enrollment in the plan outweighs the likelihood of being improperly billed for services. We recommend that duals consult with a HICAP counselor in making this decision (see Appendix A).

When an individual buys a standalone dental plan to reduce his countable income to become eligible for Medi-Cal, the individual should make sure to buy a plan that provides the most value above that already offered by Denti-Cal. Advocates should explain to the dual how this coverage should work with his Denti-Cal coverage to minimize issues.

Cal MediConnect

Cal MediConnect is a relatively new health plan type available to dual eligible beneficiaries living in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. Cal MediConnect plans are responsible for delivering all Medicare and Medi-Cal benefits under one plan. Unfortunately, dental is still carved out. But unlike other Medicare products delivered through private health plans, Cal MediConnect plan members receive their primary dental coverage through Denti-Cal. Some Cal MediConnect plans also offer supplemental dental benefits – these supplemental benefits wrap around what is delivered by Denti-Cal. Cal MediConnect plans have required that their dental providers also be enrolled in Denti-Cal to help retain continuity and minimize improper billing.

Nursing Facility Residents

Nursing facility residents have poorer oral health than the general population. This is true despite the fact that nursing facility residents retained full dental benefits under Medi-Cal when they were eliminated for adults living in the community in 2009.⁵⁵ While coverage is comprehensive, nursing facility residents face different barriers to access. For example, residents receive their oral health treatment primarily within the walls of the nursing facility since residents have a more difficult time seeking treatment in the community. The result is that most residents only receive treatment when they have an acute need and receive fewer preventive services. We hope with strong advocacy, we can change this practice. Here are specific ways to advocate for residents in nursing facilities.

Nursing Facility Residents Have Poorer Oral Health⁵⁶

50% of older adults residing in nursing facilities have untreated tooth decay.

27% of older adults need gum treatment immediately

One third of nursing facility residents have lost all their teeth

Access to Services

Nursing facilities are required to assess a resident's dental and nutritional status upon admission, and thereafter quarterly and when there is a significant change in the resident's condition.⁵⁷ Nursing facilities are required to complete the Minimum Data Set (MDS) – a federally required clinical assessment of all residents in Medicare and Medicaid certified nursing homes. Two sections of the MDS identify oral health needs. Section K includes questions around the resident's ability to swallow and their nutritional status and Section L specifically covers oral health problems including broken or loosely fitting dentures, no natural teeth, mouth ulcers or lesions, obvious cavities, broken teeth or loose teeth, mouth pain, and inflamed or bleeding gums.

If oral health needs are identified during the assessment or anytime thereafter, the facility is required to assist residents in obtaining both routine and 24-hour emergency dental care and these needs and how they are to be addressed must be included in the care planning process.⁵⁸ In practice, this often means that nursing facilities will arrange for a dentist to visit a facility on a regular basis, and residents who are experiencing acute dental issues (e.g. pain) will be signed up to be seen. But facilities are required to do more. Specifically, pursuant to federal law, facilities are directly responsible for the oral health needs of their residents.⁵⁹

The facility is required to make sure a dentist is available to residents through having a contract arrangement with a dentist or employing a staff dentist. If a resident is unable to pay for dental services, the facility is supposed to attempt to find alternative care or funding to ensure the resident has the highest practicable level of well-being. The facility is also supposed to ensure access to routine care (e.g. gum treatment, cleanings) and must, if necessary or requested, assist the resident in making dental appointments and arranging transportation to and from those dental services.⁶⁰

Nursing facilities are not permitted to charge for personal hygiene items, including dental floss, denture cleaner, denture adhesive, denture cups, toothpaste, or toothbrushes for residents who are paying for their stay through Medicare or Medi-Cal.⁶¹

Oral Hygiene

Many residents in nursing facilities are unable to carry out the activities required to maintain their oral health. For these residents, nursing facilities are required to provide services such as brushing the teeth, cleaning dentures, cleaning the mouth and tongue with a mouth wash or by manually cleaning the resident's mouth and teeth with a gauze sponge.⁶²

Lost Dentures

Nursing facility residents' dentures often go missing. This is problematic when dentures are a covered benefit only every five years under Denti-Cal. California facilities are required to establish and maintain a written inventory of a resident's property, including dentures.⁶³ Facilities are also required to engrave a resident's dentures to mark ownership.⁶⁴ Federal rules require facilities to have a policy in place that identifies instances when the loss or damage of dentures is the facility's responsibility and prohibits the facility for charging the resident for the loss or damage when the facility is at fault.⁶⁵ Facilities also must make a referral to a dental provider within three (3) business days when dentures are lost or damaged.

Advocacy Tip

Nursing facility residents with dentures should ensure their dentures are engraved and also recorded on their personal property inventory list. Residents should also take pictures of their dentures. If dentures go missing, the resident should report the loss immediately to the facility administrator, the long-term care ombudsman, and file a police report. Residents then should write a demand letter to the nursing facility requesting reimbursement for the lost dentures. With a police report, Medi-Cal beneficiaries may also be successful in obtaining new dentures through Denti-Cal.

Residential Care Facilities for the Elderly

Residential Care Facilities for the Elderly (RCFE), also referred to as “Assisted Living” or “Board and Care” are non-medical facilities for older adults who require assistance with activities of daily living. RCFEs are required to assist in arranging for dental care for residents and provide assistance with meeting dental needs, including assisting with providing or arranging transportation to dental services.⁶⁶

Residents of Intermediate Care Facilities for the Developmentally Disabled

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) provide care and support services to individuals with a developmental disability whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. California state law sets forth additional and specific requirements around the provision of dental in ICF-DDs.⁶⁷ For example, ICF-DD staff must be trained on nutrition and how to properly conduct oral hygiene. The facility also must also maintain a permanent dental record for each resident and record dental progress and have in place a formal arrangement for providing residents with dental services.

Other Oral Health Treatment Options

Some older adults do not have access to any dental coverage or only have limited coverage through Medicare or commercial plans. There are a number of options available that, while not comprehensive or always available, are worth exploring.

Federally Qualified Health Clinics – Community Clinics

There are 1,300 Federally Qualified Health Clinics or what are commonly known as community health centers (CHCs) in California that provide care to approximately 6.5 million Californians. CHCs are nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide comprehensive services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. CHCs provide a variety of community services including, primary medical care, pediatrics and prenatal care, behavioral health care, and oral health care. Many community health centers have full dental clinics that can provide more comprehensive dental services. A list of community health center offering dental services is available at: <https://www.federaldentalprograms.com/california.html>. To find a community health center by area, please visit this website: https://www.californiahealthplus.org/CHPlus/Find_My_Health_Plus_Center/CHPlus/FIND_MY_HEALTH_CENTER/Clinic_Finder.aspx?hkey=9cd9f887-b092-4439-a9bc-7032454c9273/.

Community health centers accept both Medi-Cal and Medicare as well as most commercial insurance options. CHCs serve all patients regardless of their ability to pay which makes them an attractive option for older adults seeking dental care who do not have coverage through Medicare. One barrier older adults may face when attempting to get care is long wait lists due to high demand. Many CHCs have urgent care hours and walk-in appointment slots, so it is advisable for an individual to contact the community health center in her area to determine how and when the CHC can best serve her.

Advocacy Tip

If an older adult wants to seek dental treatment at a community health center it could be advantageous to establish the CHC as the health home. This ensures the integration of all care an older adult may need. This may mean changing Medicare providers to a CHC provider or utilizing the CHC for other health care needs like behavioral health treatment if that is a need.

Community health centers are Medi-Cal providers and bill Medi-Cal for dental services rendered. If an individual has Denti-Cal coverage, but is unable to find a Denti-Cal provider in the community, seeking care at a community health center may be an option.

Veterans Affairs

The VA offers comprehensive dental care benefits to certain qualifying Veterans.⁶⁸ If the individual does not qualify for VA dental benefits, individuals enrolled in the VA health plan can enroll in a VA dental health plan for a reduced price through the VA Dental Insurance Program.

Dental Schools

There are six dental schools in California.⁶⁹ These schools often provide treatment to populations in need. Services are usually provided on a sliding scale and many dental schools will accept Denti-Cal insurance. Not all dental schools provide treatment to all populations, so it is important to contact the school to determine whom the school serves and whether the treatment sought is a service the school offers. See Appendix A for a list of schools and contact information.

Pop-Up Clinics

There are efforts to bridge gaps in access to dental care by providing care at large pop-up clinics. These clinics are generally staffed by volunteers and provide a range of different services for free. The pop-up clinics are usually set up in a public space. Keep in mind that these events are usually crowded with long waits. It is also important to do some research before traveling to a pop-up clinic to ensure the services the individual needs are being offered.

Conclusion

Oral health is essential to overall health. While California has taken a critical step in ensuring low-income older adults have fairly comprehensive coverage through Denti-Cal, barriers to accessing those benefits and quality treatment are significant. It is our intention that this Guide will help advocates navigate the system and empower them to identify and address systemic barriers to care.

Endnotes

- 1 California Department of Public Health, “Status of Oral Health in California: Oral Disease Burden and Prevention 2017,” (April 2017), available at www.cdph.ca.gov/Programs/CCDCPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf.
- 2 Center for Oral Health, “A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults,” (March 2018), available at <https://centerfororalhealth.org/wp-content/uploads/2018/03/Oral-Health-of-Older-Adults.pdf>.
- 3 Id.
- 4 National Council on Disability, “Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities,” (Fall 2017), available at https://ncd.gov/sites/default/files/NCD_Dental%20Brief%202017_508.pdf.
- 5 U.S. Dept. of Health and Human Services, “Dental Caries and Tooth Loss in Adults in the United States, 2011-2012,” (May 2015), available at www.cdc.gov/nchs/data/databriefs/db197.pdf.
- 6 U.S. Dept. of Health and Human Services, “Healthy People 2010: Understanding and Improving Health,” (Nov. 2000), available at www.healthypeople.gov/2010/Document/pdf/Volume2/21Oral.pdf.
- 7 American Journal Public Health, “Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities,” (March 2012), available at www.ncbi.nlm.nih.gov/pmc/articles/PMC3487659/. See also, GAO, “Dental Disease Is a Chronic Problem Among Low-Income Populations,” (April 2000), available at www.gao.gov/new.items/he00072.pdf.
- 8 Id.
- 9 See, California Department of Public Health, “California Oral Health Plan 2018-2028,” (January 2018), available at <https://www.cdph.ca.gov/Documents/California%20Oral%20Health%20Plan%202018%20FINAL%201%205%202018.pdf>.
- 10 Journal of Nutrition, “Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants,” (February 2010), available at www.ncbi.nlm.nih.gov/pmc/articles/PMC2806885/.
- 11 Dept. of Health and Human Services, “Oral Health in America: A Report of the Surgeon General,” (2000), available at www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf.
- 12 Id.
- 13 Id.
- 14 American Journal Public Health, “Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities,” (March 2012), available at www.ncbi.nlm.nih.gov/pmc/articles/PMC3487659/.
- 15 American Dental Association Health Policy Institute, “Oral Health and Well-Being in California,” available at <https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/California-facts>.
- 16 Dept. of Health and Human Services, “Oral Health in America: A Report of the Surgeon General,” (2000), available at www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf.
- 17 42 USC § 1395y (a)(12). “No payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in

the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.”

- 18 Id.
- 19 Medicare Benefit Policy Manual Pub. 100-02, Ch. 15 § 150. Available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF>.
- 20 MBPM CMS Pub. 100-02 Chapter 15 Section 150.
- 21 Medicare National Coverage Determination Manual, Pub. 100-03, Ch. 1, Part 4, § 260.6., available at, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf; The heart valve exception is cited on CMS’s website, but we were unable to locate the guidance that establishes this exception. To our knowledge, the exception is limited to an oral/dental examination performed at a Federally Qualified Health Center or Rural Health Clinic before heart valve replacement surgery.
- 22 For more on Medi-Cal eligibility pathways, see, Western Center on Law & Poverty, “Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates,” (March 2016), available at <https://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>; see also, “If you think you need a nursing home...A Consumer’s Guide to Financial Considerations and Medi-Cal Eligibility,” California Advocates for Nursing Home Reform (May 2018), available at http://www.canhr.org/publications/PDFs/MEB_English20180517.pdf.
- 23 There are 22 COHS counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.
- 24 There are 7 CCI Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
- 25 All pregnant women, whether on full-scope or pregnancy-related Medi-Cal are eligible for full dental benefits.
- 26 FQHC’s sued to continue to provide benefits. California Association of Rural Health Clinics v. Douglas, Nos. 10–17574, 10–17622 (9th Cir.)(2013).
- 27 WIC § 14131.10; Denti-Cal Bulletin, Vol 33, No 4, available at https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_33_Number_14.pdf.
- 28 Id.
- 29 Denti-Cal Provider Handbook, (Second Quarter, 2018; May 2018), available at https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf.
- 30 Id. at p. 4-9.
- 31 Id. at p. 2-16.
- 32 California Medi-Cal Dental Services 2018 Beneficiary Handbook, (2018), p. 24, available at https://www.denti-cal.ca.gov/DC_documents/beneficiaries/DC_beneficiary_handbook.pdf.
- 33 Denti-Cal Provider Handbook at Prosthodontics (Removable) General Policies (D5000-D5899) (1)(J); see also p. 6-34.
- 34 WIC § 14131.10(b)(1)(C); Denti-Cal Provider Manual.
- 35 Statute
- 36 2017 Denti-Cal Provider Outreach and Utilization Improvement Plan, available at <http://www.dhcs.ca.gov/services/Documents/MDS/2017DentiCalProviderOutreachPlan.pdf>.

- 37 WIC § 14134.
- 38 All Plan Letter 17-010, “Non-Emergency Medical and Non-Medical Transportation Services,” (July 2017), available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf>.
- 39 See Denti-Cal Provider Handbook Section 9-18; and bulletin http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_08.pdf.
- 40 County-Based Medi-Cal County Contacts for NEMT and NMT, available at <http://www.mchaccess.org/pdfs/alerts/Transportation-claiming%20counties%20-%20contact%20listing.pdf>.
- 41 Americans with Disabilities Act of 1990, Pub. L. No. 1010-336, 104 Stat. 328 (1990); Section 1557 of the Affordable Care Act.
- 42 Provider bulletin https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/archive/Volume_31_Number_06.pdf.
- 43 WIC § 14019.4(c).
- 44 California Civil Code § 1780; California Business and Professions Code §§ 17200 et seq.
- 45 See Denti-Cal Provider Handbook, p. 2-15.
- 46 For additional information on combating medical and dental debt, see, National Consumer Law Center, “Dealing with Medical Debt: Consumer Advice from NCLC,” (2018), available at <https://library.nclc.org/dealing-medical-debt-consumer-advice-nclc>.
- 47 Business & Professions Code § 654.3; See also, AB 171, available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200920100AB171.
- 48 Business & Professions Code § 654.3(f).
- 49 California Civil Code § 1780. Business & Professions Code § 654.3(h).
- 50 See All Plan Letter 17-006, “Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments,” available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>.
- 51 WIC §14198.8(g).
- 52 For more information on PACE, visit <http://www.dhcs.ca.gov/provgovpart/Pages/PACE.aspx>.
- 53 WIC § 14019.4; 42 U.S.C. § 1396a(n)(3)(B).
- 54 42 C.F.R. § 422.504(g)(1)(iii).
- 55 Center for Oral Health, “A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults,” (March 2018), available at <https://centerfororalhealth.org/wp-content/uploads/2018/03/Oral-Health-of-Older-Adults.pdf>.
- 56 Id.
- 57 42 CFR 483.20(b)(1)(xi).
- 58 42 CFR 483.55(a)(1) (for skilled nursing facilities); 42 CFR 483.55(b)(1) (for nursing facilities).
- 59 Surveyor’s Guideline to 42 CFR section 483.25, Appendix PP to CMS State Operations Manual.
- 60 42 CFR 483.55(a)(4).
- 61 42 CFR 483.10(f)(11)(i)(E).

- 62 42 CFR 483.25(a)(3); and Surveyor’s Guideline to 42 CFR section 483.25, Appendix PP to CMS State
Operations Manual.
- 63 HSC §1289.4(d).
- 64 HSC §1289.4(h).
- 65 42 CFR 483.55.
- 66 22 CCR § 87465.
- 67 22 CCR § 76359.
- 68 US Dept. of Veterans, “Dental Benefits for Veterans,” (2014), available at [https://www.va.gov/healthbenefits/
resources/publications/IB10-442_dental_benefits_for_veterans_2_14.pdf](https://www.va.gov/healthbenefits/resources/publications/IB10-442_dental_benefits_for_veterans_2_14.pdf).
- 69 Dental Schools of California, available at [https://www.denti-cal.ca.gov/DC_documents/providers/dental
schools_in_california3.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/dental_schools_in_california3.pdf).

Appendix A – Resources

Consumer Assistance Resources

Below is a list of consumer assistance programs that can assist with individual client issues. This is not intended to be a comprehensive list.

	Description	Website	Telephone
Health Consumer Alliance	The HCA helps individuals and families get the health care services they need, while working to identify and address systemic health care issues impacting all Californians.	https://healthconsumer.org/	888-804-3536
Asian Americans Advancing Justice, Los Angeles	Advancing Justice-LA provides legal services and education to individuals, especially those who speak little or no English.	https://www.advancingjustice-la.org/	888-349-9695
Health Insurance Counseling & Advocacy Programs (HICAPs)	HICAPs provide free, objective information and counseling on Medicare.	https://cahealthadvocates.org/	800-434-0222

The following is a list of organizations engaged in systemic oral health advocacy in California for adults.

	Website
California Pan Ethnic Health Network (CPEHN)	https://cpehn.org/
Center for Oral Health	https://centerfororalhealth.org/
Health Access	http://health-access.org/
Justice in Aging	http://www.justiceinaging.org/our-work/healthcare/oral-health/
Maternal & Child Health Access	http://www.mchaccess.org/index.php
National Health Law Program (NHELP)	http://www.healthlaw.org/
West Health	https://www.westhealth.org/
Western Center on Law & Poverty	https://wclp.org/

Written Resources

- Denti-Cal Beneficiary Handbook: https://www.denti-cal.ca.gov/DC_documents/beneficiaries/DC_beneficiary_handbook.pdf.
- Denti-Cal Provider Handbook: https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook/.

- Denti-Cal Provider Bulletins: https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Bulletins/.
- Denti-Cal Beneficiary Pamphlet (published by CPEHN, AAAJ, and Justice in Aging): <https://cpehn.org/page/what-you-need-know-restored-dental-benefits-adults-california>.
- California State Oral Health Plan: <https://www.cdph.ca.gov/Documents/California%20Oral%20Health%20Plan%202018%20FINAL%201%205%202018.pdf>.
- State of Oral Health in California Report: https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf.
- Center for Oral Health, A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults, <https://centerfororalhealth.org/wp-content/uploads/2018/03/Oral-Health-of-Older-Adults.pdf>.
- Little Hoover Commission Report, Fixing Denti-Cal (April 2016), <http://www.lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf>.
- Little Hoover Commission Follow up Letter, Denti-Cal Program Still Broken (October 2017), <http://www.lhc.ca.gov/report/letter-governor-brown-and-legislature-denti-cal-program-still-broken>.
- Justice in Aging Letter to Little Hoover Commission (February 2018), <http://www.justiceinaging.org/wp-content/uploads/2016/07/Justice-in-Aging-Oral-Health-For-Older-Adults.pdf>.

State Agencies

- Department of Public Health, Oral Health Program: <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/OralHealthProgram/OralHealthProgram.aspx>.
- Department of Health Care Services – Denti-Cal: <https://www.denti-cal.ca.gov/>.
- Department of Managed Care, <https://www.dmhc.ca.gov/>.
- California Dental Association, <https://www.cda.org/>.
- Little Hoover Commission, <http://www.lhc.ca.gov/>.

Coalitions and Federal Resources

- California Oral Health Network, <https://cpehn.org/page/california-oral-health-network>.
- California Statewide Task Force on Oral Health for People with Disabilities, <http://www.dental.pacific.edu/departments-and-groups/pacific-center-for-special-care/innovations-center/california-statewide-task-force-for-people-with-disabilities>.
- Latino Coalition for a Healthy California, <http://www.lchc.org/policy-priorities-advocacy-areas/oralhealth-2/>.
- OralHealth2020, <http://www.oralhealth.network/>.
- Center for Medicare Advocacy, <http://www.medicareadvocacy.org/>.
- Families USA, <http://familiesusa.org/initiatives/oral-health-all>.
- Oral Health America, <https://oralhealthamerica.org/>.
- Administration on Community Living, <https://www.acl.gov/programs/health-wellness/oral-health>.
- American Dental Association, <https://www.ada.org/en>.

Dental Schools

- Loma Linda University School of Dentistry, Loma Linda
- University of California, Los Angeles School of Dentistry, Los Angeles
- University of California, San Francisco School of Dentistry, San Francisco
- University of the Pacific Arthur A. Dugoni School of Dentistry, San Francisco
- The Herman Ostrow School of Dentistry of USC, Los Angeles
- Western University of Health Sciences College of Dental Medicine, Pomona

Appendix B – Denti-Cal Reason for Action Codes



Denti-Cal
California Medi-Cal Dental Program

REASON FOR ACTION CODES

1. Your aid code covers emergency services only.
2. Information submitted by your dentist about your current dental condition does not meet our minimum requirements for approval of this service.
3. The request for dental treatment marked with an "R" was changed to the procedure marked with an "S." This change was based on the information submitted by your dentist concerning your current dental condition or on program guidelines.
4. Our records show this service(s) or a similar service(s) was previously authorized, paid for, or completed. (For example: In some cases, procedures are limited to once in 12 months or once in five (5) years and cannot be authorized again except under special circumstances, which must be documented by your dentist.)
5. We are unable to verify your dentist's enrollment to participate in the program on the date the request was submitted.
6. The service as requested by your dentist, IS NOT A BENEFIT OF THE PROGRAM. Please contact your dentist for a different treatment plan.
7. You did not appear for a scheduled screening examination or failed to bring existing denture(s) (full or partial). Please contact your dentist to resubmit a request for this procedure.
8. Your dentist did not submit enough information to allow us to process this request. Please contact your dentist to resubmit a request with new information.
9. X-rays show that the tooth does not meet the requirements for a crown. At least 51% of the tooth must be missing and/or decayed. The tooth may be restored with a filling.
10. X-rays show that the tooth/teeth may have an infection; please contact your dentist as another service may be needed first.
11. Based on x-rays, your dentist's charting and/or confirmed by information we received from our screening examination, you do not have sufficient gum disease to need a deep scaling.
12. This service cannot be authorized because it is related to a denied procedure in the same treatment plan submitted by your dentist.
13. Based on the information submitted by your dentist and/or received from a screening examination, your current dental condition is stable and the requested service is not needed at this time.
14. Based on x-rays and/or confirmed by information we received from a screening examination, it has been determined that the tooth/teeth has/have worn down naturally or you have bruxism

(teeth grinding). The requested service is not a benefit of the program to restore teeth worn down naturally or by bruxism or that do not have decay or have not fractured.

15. X-rays show the tooth is too broken down and cannot be repaired. Your dentist may be able to provide a different treatment.
16. Our records show that the tooth has been restored with an acceptable filling or stainless steel crown.
17. X-rays show the service requested cannot be approved because gum disease has destroyed the bone around the tooth. Your dentist may be able to recommend a different treatment.
18. The minimum requirements for orthodontic treatment could not be verified by the Handicapping Labial-Lingual Deviation Index or submitted study models.
19. A partial denture can be a benefit only when there is a full denture on the opposite arch.
20. Root canal treatment must be satisfactorily completed before a crown can be considered.
21. Tooth is not fully developed. Your dentist may be able to recommend a different treatment.
22. Treatment is not necessary because neither x-rays nor documentation supports that there is nerve damage.
23. A stayplate can be a benefit only to replace a missing permanent front tooth.
24. X-rays show that additional extractions are necessary before the treatment plan can be approved; please contact your dentist.
25. Based on information submitted by your dentist, your teeth are in such a poor condition that the requested partial denture is not a benefit under this program.
26. Based on the information submitted by your dentist, your teeth are stable at this time and should not be replaced by a full denture.
27. Based on the information submitted by your dentist, you have no opposing full denture; therefore, you do not qualify for a partial denture. However, if you are missing front teeth, you qualify for a stayplate.
28. Based on x-rays, your dentist's charting, and/or confirmed by information we received from our screening examination, your teeth and/or gums are in such poor condition that the requested treatment is not a benefit under this program. Your dentist may be able to recommend a different treatment.
29. Deep scaling and gum treatments are not a benefit for children, except for cases where medications have caused the overgrowth of gum tissue.
30. Fixed bridges are allowable when severe epilepsy, paraplegia or uncontrollable spasticity prevents the use of a removable denture.
31. Tooth is not in its normal position and cannot be repaired under this program.
32. Based on information received from a screening examination, your existing denture is satisfactory at this time.
33. Based on information received from a screening examination, it has been determined that you cannot adapt to a denture because of physical limitations or health conditions.

34. The requested service is not necessary because there are enough teeth remaining in this arch to support the opposing denture.
35. During your screening examination, you indicated you do not want extractions or any other dental services at this time.
36. The number of authorized visits has been adjusted because you will turn 21 years of age before treatment is completed. Please make arrangements with your dentist.
37. The tooth is not visible on the submitted x-rays.
38. Based on x-rays and/or confirmed by information we received from our screening examination, you need additional treatment from your dentist before the procedure can be considered.
39. X-rays show there is not enough space present for the requested false tooth.
40. This program does not cover orthodontics when there are still baby teeth present.
41. Based on x-rays and/or confirmed by information we received from our screening examination, we have determined that you have bruxism (teeth grinding). The treatment of bruxism is not a benefit of this program.
42. The procedure is not a benefit for a baby tooth or for a baby tooth ready to fall out. Your dentist may be able to recommend a different treatment for your condition.
43. The procedure requested will not correct your dental problem. Your dentist may be able to recommend a different treatment for your condition.
44. Based on information received from your dentist, it is determined that the requested service is for cosmetic reasons only. Services for cosmetic purposes only are not a benefit of the program.
45. Your current denture can be made satisfactory by a laboratory reline.
46. We are unable to verify your eligibility in this program.
47. Your dentist must contact California Children's Services prior to submitting this procedure for payment or authorization.
48. EPSDT-Supplemental Services are not a benefit for patients 21 years and older.
49. The EPSDT-Supplemental Service(s) requested is not medically necessary.