TENNCARE℠ EPSDT
OFFICE REFERENCE MANUAL

Managed by DentaQuest USA Insurance CO., LLC.

PO Box 2906
Milwaukee, WI 53201-2906
855-418-1623

The Office Reference Manual is subject to periodic updates; please ensure that you are using the latest version. The most current copy can be found online at www.dentaquest.com. Go to the Tennessee link and go to the provider resources tab to view.
Each quarter you can find what sections received updates or changes in your provider newsletter.

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Introduction

Addresses and Telephone Numbers

DentaQuest Customer Service
Member Services: 855.418.1622
Provider Services: 855.418.1623
PO Box 2906
Milwaukee, WI 53201-2906

Fax numbers:
Claims to be reprocessed: 262.834.3589

Claims Questions:
denclaims@dentaquest.com

Eligibility or Benefit Questions:
denelig.benefits@dentaquest.com

TDD/TTY (Hearing Impaired):

800.466.7566

Special Needs Member Services:

800.660.3397

TennCare Fraud Hotline:

800.433.3982

Web Site:

www.dentaquest.com

State of Tennessee
Division of TennCare℠
310 Great Circle Road
Nashville, TN 37243
http://www.tn.gov/tenncare/

Credentialing
PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Authorizations should be sent to:
DentaQuest – TennCare Authorizations
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.241.7150 or 888.313.2883

Outpatient/Hospital
Fax: 262.834.3575

Dental claims should be sent to:
DentaQuest – TennCare Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Direct entry on the web www.dentaquest.com
Or, Via Clearinghouse – Payer ID CX014
Include address on electronic claims:
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

Provider Appeals
DentaQuest – TennCare Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.834.3452
Or Via Provider Web Portal

TennCare℠ Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
800.878.3192

TennCare Connect
855.259.0701

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Tagline & Notice Templates

Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-855-418-1622 (TRS:711).

Kurdish: کوردی
ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-855-418-1622 (TRS:711).. بکە

Arabic: العربية
ملحوظة: اذا كنت تتكلم اللغة العربية خدمات المساعدة اللغوية متوفرة لك مجانا. اتصل برقم 1-855-418-1622 (TRS: 711) (رقم هاتف الصم والبكم:

Chinese: 繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-418-1622 (TRS:711).**

Vietnamese: Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-418-1622 (TRS:711).

Korean: 한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-418-1622 (TRS:711).번으로 전화해 주십시오.

French: Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-418-1622 (TRS:711).

Amharic: አማርኛ
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-8855-418-1622** (መስማት ለተሳናቸው:**TRS:711).**

Gujarati: �જરાતી
�ચુ ના: જો તમે �જરાતી બોલતા હો, તો િન:�ુ ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો
1-855-418-1622 (TRS:711) .

Laotian: ພາສາລາວ
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-855-418-1622 (TRS:711).**

German: Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-418-1622 (TRS:711).

Tagalog: Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-418-1622 (TRS:711).

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Hindi: �ह�द�

ध्यान द�: यद आप �ह�द� ब ोलत े ह� त ो आपक े �लए मफ़्त म भाष ा सह ायत ा सेव ाए ं उपलब ्ध ह�।1-855-418-1622

(TRS:711) . पर क ॉल कर�।

DentaQuest LLC January 1, 2022
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Serbo-Croatian: Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-418-1622 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian: Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-418-1622 (телетайп: TRS:711).

Nepali: नेपाल�
ध्यान �दनुहोस्: तपाइले नेपाल� बोल्नुहुन्छ भने तपाइ�को �निम्त भाषा सहायता सेवाहरू �न:शुल्क रूपमा उपलब्ध छ । फोन गनर्ुहोस् 1-855-418-1622 (�ट�टवाइ: TRS:711 ।

Persian: فارسی
با تماس . اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد:توجه بگیرید(TRS:711). 1-855-418-1622

- **Do you need help talking with us or reading what we send you?**
- **Do you have a disability and need help getting care or taking part in one of our programs or services?**
- **Or do you have more questions about your health care?**

Call us for free at 855-418-1622 We can connect you with the free help or service you need. (For TRS call: 711)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

TennCare Office of Civil Rights Compliance 310 Great Circle Road, 3W Nashville, Tennessee 37243 Email: HCFA.Fairtreatment @tn.gov Phone: 855-857-1673 (TRS 711)	MCO Information DentaQuest PO Box 2906 Milwaukee, WI 53201-2906 855-418-1622	U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Ave SW, Rm 509F, HHH Bldg Washington, DC 20201 Phone: 800-368-1019 (TDD): 800-537-7697
You can get a complaint form online at: https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf		You can get a complaint form online at: http://www.hhs.gov/ocr/office/file/index.html Or you can file a complaint online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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Program Objective

The primary objective of TennCare's Medicaid Dental program is to create a comprehensive dental care system offering quality dental Covered Services that are Medically Necessary to eligible Tennessee residents. We emphasize early intervention and promote access to necessary dental care, thereby improving health outcomes for Tennessee residents.

Are you building a "Dental Home" for your members?

Effective October 1, 2013, DentaQuest USA Insurance Company, Inc. (DentaQuest) will be implementing the Dental Home program in Tennessee for Medicaid Members.

The Main Dental Home is a place where a child's oral health care is delivered in a complete, accessible and family-centered manner by a licensed dentist. This concept has been successfully employed by primary care physicians in developing a "Medical Home" for their Members, and the "Dental Home" concept mirrors the "Medical Home" for primary dental and oral health care. If expanded or specialty dental services are required, the general dentist is not expected to deliver the services, but to coordinate the referral and to monitor the outcome.

Provider support is essential to effectively employ the Dental Home program for Medicaid Dental Program Members. With assistance and support from dental professionals, a system for improving the overall health of children in the Medicaid Program can be achieved.

Dental Home Initiative

Providers who are contracted with DentaQuest for the TennCare Program will automatically be included in the Dental Home Initiative.

For additional information regarding the Dental Home program, please connect to the DentaQuest Provider Web Portal www.dentaquest.com under Related Documents – Dental Home.

Assigning members to a Dental Home

DentaQuest's Dental Home auto-assignment function follows the below hierarchy when assigning members to a dental home:

- If the member has history with a provider office, the member is assigned to the provider office with which they have history in order to support the continuation of an existing provider/member relationship.
- If the member does not have history with a provider office, but they have a family member that is assigned to a provider office, the member is assigned to the same provider office that their family member is linked to. This ensures family members are kept together.
- If the member does not have history or a family member assigned to a dental home, the member is assigned to the closest higher-performing provider office that is accepting new members and has open capacity.

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Member choice:

- A member may change their Dental Home at any time by calling the Customer Care team.

Provider Optimization
The intent of Provider Optimization is to increase access to care, ensure quality and reduce costs.

- To support Provider Optimization, DentaQuest:
    - Monitors provider performance on a regular basis and delivers the Provider Performance Report which measures provider performance in these areas: a) Silver Diamine Fluoride, b) Sealants, c) Fluoride Treatments and identifies those providers that consistently deliver higher-quality care at an appropriate price point and those providers that need to improve.

Reserves the right to move members away from their currently assigned dental home to a dental home providing higher-quality, lower-cost care if their current dental home has a history of performing lower-quality, higher cost care.

Providers are strongly encouraged to attend a minimum of one patient centered dental home webinar annually. The patient centered dental home is an important part of our partnership with you to enhance member participation and improve quality of care. Webinars will include helpful hints and practical information on how to increase your recalls and use the resources such as panel rosters in your practice patient outreach.

Outreach and Wellness Initiatives

Through collaborative efforts with dental providers DentaQuest will work to improve the overall oral health of the Members served through the TennCare program, increase access to care, and assess, prevent and manage oral disease. Annually DentaQuest will launch a comprehensive outreach program to reach Members encouraging them to establish a dental home, have regular preventive check-ups and take an active role in oral health care.

Our *It Takes Two* dental home program emphasizes the many benefits of establishing a dental home, developing a PCD relationship and regular preventive care (EPSDT) including sealants and fluoride treatments. Dental Homes will be established for Members through an assignment process.

We connect with Members to stress that preventive care is one of the best ways to achieve good oral and overall health. We disseminate this message to Members and their parents by employing multiple communications channels. These include; as part of the DentaQuest TennCare Annual Access Proposal:

- Member handbook
- Provider directory
- Welcome packets
- Annual appointment reminder (EPSDT)

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- Broken appointment postcard
- Non-compliant reminders
- Member newsletters
- Grassroots rural, community and screening outreach events statewide
- Oral Health Matters – an educational series on important oral health topics
- Through providers via prevention-based programs, provider web portal and
- provider newsletters.

As the initiatives are launched dental providers will receive additional information about the It Takes Two Dental Home and Preventistry programs.

Becoming a Dental Outreach Volunteer

Want to help children learn how important their teeth are? Do you want to do something satisfying and of great service to your community? Then become a Dental Outreach volunteer!

Volunteers are wanted across Tennessee to assist with a variety of outreach events regarding the importance of children's oral health. Licensed dentists are needed to provide brief dental screenings and general volunteers to assist with registration and oral health education.

Each outreach event only lasts a few hours but is extremely beneficial to children and families. All dental screening supplies are furnished, and outreach staff is always available to support volunteers in any way necessary.

Medically Necessary Covered Services

DentaQuest is responsible for administering TennCare-covered dental benefits as medically necessary for Medicaid eligible Members. A comprehensive list of the Covered Services codes can be found in Exhibit A of this manual. DentaQuest must provide coverage in a manner which satisfies all regulatory rules and regulations established through Tennessee's Medicaid Managed Care Program by The State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare.

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DentaQuest

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DentaQuest

1.00 General Information

1.1 Member Rights and Responsibilities

A. Introduction

The mission of DentaQuest is to expand access to high-quality, medically necessary, and compassionate health care services within the allocated resources. DentaQuest is committed to ensuring that all TennCare Program Members (Members) are treated in a manner that respects their rights and acknowledges Members' responsibilities. Members have the right to receive medical services and have certain responsibilities to aid in receiving them in accordance with TennCare℠ Rules 1200-13-01 et seq. The following is a statement of Member Rights and Responsibilities.

B. Member Rights

As a Member of TennCare℠, Member rights include but are not limited to the following:

- to be treated with respect and recognition of their dignity and need for privacy;
- to be provided with information about the organization, its services, the practitioner providing care, and Member rights and responsibilities;
- to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;
- to participate in decision-making regarding their dental care;
- to voice complaints or appeals about the organization or care provided;
- to be guaranteed the right to request and receive a copy of his or her dental records and to request that they be amended or corrected as specified in 45CFR part 164;
- to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- to be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the DBM and Its providers or The State agency treat the Member, and;
- to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.

Additional Member rights are as follows:

<u>**Confidentiality**</u>

All dental information about TennCare℠ Members is confidential. Members have the right to be treated with respect and recognition of their dignity and need for privacy when receiving their dental care. Provider and DentaQuest will ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization. Provider and DentaQuest shall hold confidential all information obtained by its personnel about Members related to

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their examination, care and treatment and shall not divulge it without the Member's authorization, unless:

- it is required by law;
- it is necessary to coordinate the Member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
- it is necessary in compelling circumstances to protect the health or safety of an individual.

Release of information shall be reported to the Member prior to disclosure to give the Member sufficient time to object should the Member wish to. Member records may be disclosed, whether or not authorized by the Member, to qualified personnel for the purpose of conducting scientific research that has been approved by an Institutional Review or Privacy Board, but these personnel may not identify, directly or indirectly, any individual Member in any report of the research or otherwise disclose participant identity in any manner.

DentaQuest and the Provider shall ensure all materials and information directly or indirectly identifying any current or former Member which is provided to or obtained by or through DentaQuest's performance of its contract with TennCare, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated (T.C.A.), Title 42, Part 2, Code of Federal Regulations, the Privacy Act of 1974, 5 USC 552a, the Medicaid regulations, 42 Code of Federal Regulations 431.300 et seq., IRC Section 6103(p), and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to TennCare, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees.

Informed Consent

A Member's consent is required for all treatment, unless there is an emergency and the Member's life is in serious danger. Members have the right to participate in decisions regarding their health, including consent to have invasive treatment. If written consent is required for special procedures, such as surgery, Members must understand the procedure and why it is advised. Should Members not want a particular treatment, they have the right to discuss their objections with their Provider, who will advise and discuss options. The final decision is up to the Member.

Emergency Services

A member can access a DentaQuest dentist for emergencies 24 hours a day, seven days a week. An enrollee should ask their provider how to contact him or her in an emergency. Their provider may have a different telephone number to call in an emergency.

Dental Records

Members have the right to request access to their dental records as provided by State and federal laws. When transferring to another dental provider, Members have the right to request access to their dental records free of charge.

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Members have the right to request restriction of uses and disclosures. Provider must accommodate reasonable requests by Members to receive communications of PHI from the provider by alternative means or at alternative locations.

Provider must permit Members to request that the provider amend the PHI in the Member's record. Provider may require that Members make the request in writing and provide a reason to support a requested amendment.

Members have the right to receive an accounting of disclosures in the six (6) years prior to the date the Member requests the accounting.

For the most up to date and detailed information regarding HIPAA and Member rights go to http://www.hhs.gov/ocr/privacy/index.html

Discrimination

Not being discriminated against by your health care Provider on the basis of your age, sex, race, color, religion, physical or mental handicap, national origin, economic status or payment source, type/degree of illness or condition, or any other classification protected by federal and state laws and regulations.

Providers shall agree to cooperate with TennCare and DentaQuest during discrimination complaint investigations. In addition, the Provider must assist TennCare enrollees in obtaining discrimination complaint forms and assistance from DentaQuest with submitting the forms to TennCare. A copy of the Complaint form and notice of fair treatment can be found online; see Appendix A of this document for a full list of forms.

DentaQuest and the Provider shall comply with Title III of the Americans with Disabilities Act of 1990 in the provision of equal opportunities for enrollees with disabilities. In the event that a reasonable modification or effective communication assistance in alternative formats for an enrollee is not readily achievable by the Provider, DentaQuest shall provide the reasonable modification or effective communication assistance in alternative formats for the enrollee unless DentaQuest can demonstrate that the reasonable modification would impose an undue burden on DentaQuest.

Auxiliary aids and services are available under Title III of the ADA and Section 504 of the Rehabilitation Act of 1973. For more guidance see:

www.ada.gov
http://www.ada.gov/taman3.html
http://www.hhs.gov/ocr/civilrights/resources/laws/index.html

Non-Discrimination Compliance Offices

Contact information for non-discrimination compliance offices are as follows:

Bureau of TennCare

- **Phone**: 615.507.6474
- **E-mail:** Tenncare.fairtreatment@tn.gov

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You can also write to:

Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

DentaQuest

- **Phone**: 262.834.3576
- **E-mail:** DentaQuest.fairtreatment@dentaquest.com

You can also write to:
Non-discrimination Compliance Coordinator
DentaQuest of Tennessee, LLC
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 800.241.7366
TDD: Toll Free 1.800.417.7140 ext. 43576
Local 262.834.3576

Language Assistance Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. The Executive Order signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to **TennCare**SM and it is not permissible to charge a TennCare Member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found on line at http://www.justice.gov/crt/about/cor/coord/titlevi.php.

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of **TennCare**SM Members. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found on line at http://www.lep.gov/ISpeakCards2004.pdf.

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers cannot locate interpreters specializing in meeting needs of LEP clients by calling the translation numbers listed at the front of this guide.

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

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Advance Directives
Members have the right to determine their treatment by issuing advance directives (legal provisions that allow their wishes to be carried out when they are incapable of making important health decisions). These directives may include:

- A living will to express the Member's wishes concerning life-sustaining treatment by artificial means when terminally ill;
- A durable A durable power of attorney for health care that gives an individual appointed by the Member the authority to make decisions regarding the Member's treatment; or
- Nominating a guardian or conservator, a court-appointed individual who represents the Member's interests when he/she is unable to make independent decisions.

Member Appeals
Members shall have the right to file appeals regarding adverse actions taken by DentaQuest or the Provider. The term "Appeal" shall mean a Member's right to contest verbally or in writing, any "Adverse Action" taken by DentaQuest or the Provider to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of DentaQuest or the Provider that impair the quality, timeliness, or availability of such benefits. An Appeal may be filed by the Member or by a person authorized by the Member to do so, including but not limited to, a Provider with the Member's consent. DentaQuest shall inform Members of their Appeal rights in the Member Handbook. See section 7.00 of this manual for specific Appeal guidelines.

Member Complaints
A Member "Complaint" shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does NOT meet the definition of Adverse Action. For example, a Complaint may arise due to how the Member was treated by the Provider or the Provider's staff during an office visit (i.e. rude or inappropriate behavior or not answering the Member's questions) or if the Member feels that a DentaQuest staff Member treated him/her inappropriately (i.e. being rude during a phone call, or not returning a Member's phone calls). DentaQuest shall inform Members of their Complaints rights in the Member Handbook. TennCare takes Member's Complaints very seriously and requires DentaQuest and DentaQuest's Providers to do the same. See section 7.03 of this manual for specific guidelines pertaining to handling Member Complaints.

Information
Members have the right to be provided with information about the services offered by TennCare^SM^, DentaQuest, or the dental practitioner providing the care and their own personal rights and responsibilities.

C. Member Responsibilities
Enrollment in TennCare^SM^ carries certain Member responsibilities. While all Members receive a handbook that details those responsibilities, Providers are also encouraged to familiarize themselves with Member responsibilities.

Those responsibilities include:

- Knowing and understanding the terms, conditions and provisions of TennCare^SM^ and DentaQuest and abiding by them.

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- Informing the Customer Service Department at DentaQuest, TennCare[SM], and his/her Department of Children's Services (DCS) case worker regarding any change in residence and any circumstance which may affect entitlement to coverage or eligibility.
- Following preventive health guidelines, prescribed treatment plans and guidelines given by those providing health care services.
- Scheduling or rescheduling appointments and informing your Provider when it is necessary to cancel an appointment.
- Showing your TennCare[SM]/MCO ID card whenever you receive health careor prescription medication.
- All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health services.
- All Members have the responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
- All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

1.2 Provider Rights and Responsibilities

A. DentaQuest Participating Providers have a right to:

- Receive information about TennCare[SM], its services, and its Members' rights and responsibilities.
- Be informed of the status of their credentialing or re-credentialing application, upon request.
- Object to rules, policies, procedures, or decisions of DentaQuest or TennCare[SM], as set forth in this document and your provider agreement.
- File an appeal as delineated in this Provider Office Reference Manual.
- Not be discriminated against with regard to participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- Not be discriminated against for specializing in conditions that require costly treatment.
- Recommend a course of treatment to a Member, even if the course of treatment is not a Covered Service or approved by TennCare[SM]. However, the Provider must inform the Member that TennCare[SM] will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare[SM] program.
- Communicate with Members regarding dental/treatment options.
- Specify the functions and /or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional practice. However, TennCare[SM] will only pay for covered

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services that are medically necessary that the Member is eligible to receive under the TennCare[SM] program.

- Discontinue treatment of a Member with whom the practitioner feels he/she cannot establish or maintain a professional relationship.
- Recommend input into TennCare's Rules, Policies and Procedures. These Rules, Policies and Procedures are available on the DentaQuest's website, www.DentaQuest.com.
-

B. TennCare[SM] Participating Providers have the responsibility to:

- Screen all employees and contractors to determine whether any of them have been excluded from participation as a Medicaid provider. This obligation is a condition of a Provider's enrollment as a Medicaid provider and is also a continuing obligation during a Provider's entire term as such. Provider acknowledges that as a Medicaid provider, Provider is required and agrees to search the Health and Human Services Office of Inspector General (HHS-OIG) website monthly to learn of persons who have been excluded and reinstated as Medicaid providers. Provider is required and agrees to immediately report any exclusion information discovered relating to its employees or contractors to DentaQuest. The National Practitioner Data Bank (NPDB) is a federal data bank which was created to serve as a repository of information about health care providers in the United States. NPDB can be used a source of data to obtain any exclusions reported regarding a given provider.
- Recognize and abide by all applicable State and Federal laws, regulations, rules, policies, court orders and guidelines and the requirements of the Provider Agreement, its attachments, and this DentaQuest Office Reference Manual (ORM). This includes monthly checks of the Providers' employees and contractors against the federal U.S. Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities (LEIE) database for excluded providers.
- The provider shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, the Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (TBI MFCU), Department of Health and Human Services Office of the Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, TennCare or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ;
- Assist in such reviews including the provision of complete copies of dental records.
- Provide at no cost to a Member or Member's new dental Provider all dental/medical records, when care is being transferred to another dentist.
- Allow participation by the Member in the decision-making regarding the Member's dental care.

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- Discuss appropriate or medically necessary treatment options for the Member's conditions, regardless of cost or benefit coverage. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare program.
- Provide information that TennCare and DentaQuest require to evaluate the quality of care and service.
- Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.
- Serve as a conduit to the practitioner community regarding the dissemination of health care information.
- Notify Member in writing if a recommended service or supply is not a Medically Necessary Covered Service and obtain a written waiver from the Member prior to rendering such service that indicates the Member was aware that such service or supply is not a Medically Necessary Covered Service and that the Member agrees to pay for such service or supply if provided.
- Abide by the accessibility and availability standards as set forth in Section 3 of the Provider Agreement.
- Ensure that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

C. Annual Informational Sessions and Webinars

DentaQuest and the Division of TennCare strongly encourage all providers to attend as many offered sessions as possible and a minimum of one annually. Invitations to sessions and webinars will be posted on the portal and sent via email so you can attend.

1.3 Provider Data and Operations

A. Updating Your Information

It is important to ensure that you provide updates to DentaQuest at least 30 days in advance for any changes in information for your practice per your provider agreement. The Division of TennCare has requested we send out all communications by email so having a valid up to date email on file with DentaQuest is critical to ensure you receive all communications in a timely manner. What you provide to DentaQuest should match what you attest to quarterly in CAQH. An update form can be found in the forms section of this manual and should be emailed to standardupdates@dentaquest.com

Types of updates:

- Business (Tax ID)
- Credentialing Correspondence
- EFT/Payment
- License Change
- Name Change
- Location (Provider) Add/Term/Update

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DentaQuest

B. Existing Patients Only Policy

DentaQuest has updated the policy in regard to existing patients only. The following criteria has been implemented for existing patient only (EPO) requests:

- 30 day advance written notice and a completed update form is required to be submitted
- Requests will be honored for a 90-day span from date of submission
- At the end of the 90-day timeframe your EPO status will be removed

C. TennCare Policy Links

- Timely Filing
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pay06002.pdf
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf
- Coverage Adult Dental in ER
  https://www.tn.gov/content/dam/tn/tenncare/documents2/ben06002.pdf
- Cost Effective Alternatives
  https://www.tn.gov/content/dam/tn/tenncare/documents2/ben08001.pdf
- False Claims Act Policy
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pi08001.pdf
- Orthodontia Providers
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pro05001.pdf
- Provider Terminations for Inactivity
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pi13001.pdf

The policies below are for provider billing:

- Third Party Co-Pays and Deductibles
  https://www.tn.gov/content/dam/tn/tenncare/documents2/con05001.pdf
- Third Party Liability
  https://www.tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf
- When A Provider May Bill A TennCare Enrollee
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pro08001.pdf

1.4 TennCare Kids Program

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), aka TennCare Kids, services of Members under age 21 shall be made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and provide treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare program. Pursuant to 42 USC §1396d(r), EPSDT services shall at a minimum include:

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A. Screening services provided at intervals:

a. which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care

b. indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions

B. Dental Services which are provided:

a. at intervals which meet reasonable standards of dental practice as determined by the State after consultation with recognized dental organizations involved in child health care and

b. at such other intervals, indicated as Medically Necessary, to determine the existence of a suspected illness or condition and

c. which shall at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare program.

C. Transportation assistance

for a child includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary.

Member should contact the Transportation Services number provided by the Member's Managed Care Organization (MCO) to arrange transportation services.

D. Other necessary health care

diagnostic services, treatment, and other measures described in Section D to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare Program.

E. Definitions

42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, screenings must include, but are not limited to:

a. Comprehensive health and developmental history;

b. Comprehensive unclothed physical examination;

c. Appropriate vision testing;

d. Appropriate hearing testing;

e. Appropriate laboratory tests;

f. Dental screening services furnished by direct referral to a dentist for children

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beginning at 3 years of age

Again, these screening services must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatric Dentistry Guidelines. Pursuant to the TennCare[SM] Dental Benefits Manager Contract with DentaQuest "screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care.'"

Should screenings indicate a need, the following services must be provided, even if the services are not included in the Plan if it is determined that they are covered services that are medically necessary under the TennCare Program:

a. Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
b. Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and
c. Appropriate immunizations

<u>Periodicity of Examination, Preventative Dental Services, Anticipatory Guidance and Oral Treatment for Children (as updated by the TennCareSM Medical/Dental Director)</u>

Birth-12 Months

1. Complete the clinical oral assessment and appropriate diagnostic tests to assess oral growth and development and/or pathology.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supra- and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste), and provide counseling regarding fluoride. Prescribe systemic fluoride supplements if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast feeding, and provide counseling as needed.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for non-nutritive oral habits (digit, pacifiers, etc.).
9. Provide diagnosis and required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian.
11. Consult with the child's physician as needed.

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12. Based on evaluation and history, assess the patient's risk for oral disease.

12-24 Months

1. Repeat Birth-12 month procedures every six months or as indicated by individual patient's needs/susceptibility to disease.
2. Review patient's fluoride status, including any childcare arrangements which may impact or systemic fluoride intake and provide parental counseling.
3. Provide topical fluoride treatments every six months or as indicated by the individual patient's needs.

2-6 Years

1. Repeat 12-24 month procedures every six months or as indicated by individual patient's needs/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every six months or as indicated by the individual patient's needs.
4. Provide topical fluoride treatments every six months or as indicated bythe individual patient's needs.
5. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
6. Provide counseling and services (athletic mouth guards) as needed for orofacial trauma prevention.
7. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
8. Provide diagnosis and required treatment and/or appropriate referral for and oral diseases, habits, or injuries as indicated.
9. Assess speech and language development and provide appropriate referral as indicated.

6-12 Years

1. Repeat 2-6 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease.
2. Provide substance abuse counseling (smoking, smokeless tobacco, etc.).

12-20 Years

1. Repeat 6-12 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease.
2. At an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing oral care.

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2.00 Member Eligibility Verification

2.1 State Eligibility System

The State of Tennessee provides the most up to date online eligibility access.
For instructions, please go to
https://tcmisweb.tenncare.tn.gov/tcmis/tennessee/Security/logon.asp

2.2 DentaQuest Eligibility System

DentaQuest does not issue eligible Members ID cards. Cards are often out of date or lost by Members. It is the Provider's responsibility to check the databases available to confirm eligibility before providing services. TennCare will only pay for covered services that are medically necessary and that the Member is eligible to receive under the TennCare program. If the Provider fails to verify that the Member is eligible for the services rendered and it is later determined that the Member was not eligible, TennCare will not pay the Provider for the services rendered, and the Provider may not collect or attempt to collect the cost of such services from the Member, except as provided in Section 2.04 below.

Dental benefits end for TennCare patients at 12:00 AM on their 21st birthday. Example: Member's 21st birthday is June 1 so their dental benefits end at 12 am June 1, and they are no longer eligible for services starting that day. Members may still be on TennCare (and show eligible on the portal) but they will no longer have dental as part of their benefits.

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed via www.dentaquestgov.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department at 855-418-1623; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Internet website currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or the Member's full last name and first initial. To access the eligibility information via DentaQuest's website, simply go to our website at www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 855-418-623. Once logged in, select "Patient" and then "Member Eligibility Search" and from there enter the applicable information for each Member you are inquiring about. You are able to check on an

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unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at 855- 418-1623. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, (i.e. Member history), which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at 855-418-1623.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the Member's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the Member ID.
7. Does the Member's ID have only numbers in it? If so, press or say

   2. When prompted, enter the Member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another Member, get benefit information, get limited claim history on this Member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 855-418-1623. They will be able to assist you in utilizing either system.

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2.3 Member Cost Sharing Responsibilities

The Provider shall contact DentaQuest for Member specific co-payment information. Co-payment of "non-preventive" dental services applies as follows.

A sliding scale schedule (as outlined below) is used in determining applicable cost sharing responsibilities for TennCare Members and is applied according to the enrollee's income.

Co-Pay	0 to 100% of Poverty	101-199% of Poverty	200% and Above Poverty
Dental Visits	0	$5 per visit	$20 per visit

Cost sharing responsibilities shall apply to services other than the Preventive Dental Services for Children Under 21 Years of Age described in the table below. The procedure code listing for preventive services is as follows:

D1110	Prophylaxis –adult (when billed for children over age 13 and under age 20)
D1120	Prophylaxis - child
D1206	Topical Fluoride Varnish
D1208	Topical Application of Fluoride
D1351	Sealant per tooth

2.4 Member Liability

Providers may seek payment from Members only in the following situations:

- If the services are not covered by the TennCare program and, prior to providing the services, the Provider informed the Member the services are not covered. The Provider is required to inform the Member of the non-covered service and have the Member acknowledge the information. If the Member still requests the service, the Provider shall obtain such acknowledgment in writing prior to rendering the service.
- If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the Member that the services are not covered, the Member may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- Dates of service indicate that the Member was not eligible.

Providers may not seek payment from DentaQuest Members when:

- The Provider knew or should have known about the Member's TennCare eligibility or pending eligibility prior to providing services.

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- The claim(s) submitted to DentaQuest for payment was denied due to Provider billing error or a DentaQuest claims processing error.
- The Provider accepted DentaQuest assignment on a claim and it is determined that a primary plan paid an amount equal to or greater than the TennCare allowable amount.
- The Provider failed to comply with TennCare policies and proceduresor provided a service that lacks Medical Necessity or justification.
- The Provider failed to submit or resubmit claims for payment within the time periods required by DentaQuest.
- The Provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the Member presents another form of insurance, the Provider must determine whether the Member is covered under TennCare.
- The Provider failed to inform the Member prior to providing a service not covered by TennCare that the service was not covered, and the Member may be responsible for the cost of the service. Services, which are non-covered by virtue of exceeding limitations, are exempt from this requirement.
- The Member failed to keep a scheduled appointment(s).
- The Provider failed to follow Utilization Management (UM) notification or prior authorization policies and procedures.

2.5 Coordination of Benefits

TennCare℠ is the payer of last resort. Dental claims submitted to DentaQuest for payment by TennCare℠ must be submitted to the primary dental insurance (when applicable) prior to submission to DentaQuest for payment.

Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim to DentaQuest for payment by TennCare and ensuring that TennCare is the payer of last resort. Always submit the primary payment on the claim submitted.

Please confirm that this has been completed prior to submitting claims to DentaQuest to avoid delayed reimbursement.

In Accordance with TennCare Policy No. CON05-001 – TennCare's payment for a covered service, less any applicable Medicaid deductibles or copays is considered payment in full. Participating providers are required to accept TennCare's payment as payment in full.

2.6 DCS Immediate Eligibility

The Department of Children's Services (DCS) assigns children taken into State custody 45 days of immediate TennCare℠ eligibility. Children who have been granted such coverage may not have a TennCare℠ Identification Card. These children will make appointments as regular TennCare℠ Members, and will come to the appointment with a letter stating the following:

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- Please accept this letter as confirmation that the Member listed above has immediate eligibility in TennCare^{SM} Select.
- This letter should be used to access all covered benefits.
- The eligibility period spans (date) to (date).
- If you contact the Division of TennCare^{SM} eligibility line or verify eligibility via MediFax, the above Member may not have TennCare^{SM} eligibility.
- This child is in DCS custody, we have approved temporary eligibility in TennCare^{SM} Select.
- The Division of TennCare^{SM} will determine if permanent eligibility is applicable for this Member beyond the above time frame. If the Division of TennCare^{SM} does not approve permanent eligibility, benefits through TennCare^{SM} Select will cease on (date).
- TennCare^{SM} Select will honor and reimburse covered services rendered during the immediate eligibility period, as indicated at the top of this letter.

Regardless of who is stated in the letter as the assigned MCO (i.e. TennCare^{SM} Select, etc.) all dental claims should be sent to DentaQuest. All dental claims to DentaQuest for DCS children with “45 days immediate eligibility” should be sent to DentaQuest with a copy of the eligibility letter attached.

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3.00 Utilization Management

3.1 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular

program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These "budgeted" dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

3.2 Community Practice Patterns

DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this in mind, DentaQuest's Utilization Management Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

Where community practice patterns are inconsistent with TennCare's medical necessity criteria and the dental necessity guidelines presented in this Office Reference Manual, TennCare Rules and dental necessity guidelines will take precedence. Procedures that have been identified as inconsistent with these policies should not be included in any statistical analysis or evaluation of provider performance. For example, if a community of dentists practice prophylactic stainless steel crown use, which is excluded from coverage under TennCare because it does not comport with TennCare's rules for medical necessity, these procedures will be excluded from provider averages and comparisons.

3.3 Evaluation

DentaQuest's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and

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- Treatment cost effectiveness.

3.4 Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, DentaQuest's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

3.5 Medical Necessity Guidelines

Medically Necessary is defined by statute in TCA § 71-5-144. These laws are implemented in TennCare rules 1200-13-13-.01 and 1200-13-16 as well as the clinical criteria in this manual. The following are the basic medical necessity criteria.

To be medically necessary, a medical item or service must satisfy each of the following criteria:

- It must be recommended by a licensed physician who is treating the Member or other licensed healthcare provider practicing within the scope of his or her license who is treating the Member;
- It must be required in order to diagnose or treat a Member's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the Member's medical condition.

The convenience of a Member, the Member's family, the Member's caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.

All medically necessary covered services, including continuation of services, are provided, whether the condition existed prior to any screening and regardless of whether the need for such services was identified by a provider whose services had received prior authorization from DentaQuest or by an in-network provider. DentaQuest does not employ or allow others to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based upon the needs of each TennCare Member and his/her history.

If a participating Provider fails to comply with the medical necessity guidelines for any procedure, DentaQuest will initiate corrective action, which may include imposition of prior authorization for this procedure.

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DentaQuest

4.00 Inpatient and Outpatient Hospital Services

4.1 Prior Authorization

Any proposal to render covered services that are medically necessary in an inpatient or outpatient surgical setting must be submitted to DentaQuest for prior authorization of dental treatment to be performed in the medical facility. The request must include:

- Completed TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form, see Appendix A of this manual,
- Copy of the patient's dental record including health history, charting of the teeth and existing oral conditions,
- Diagnostic radiographs or caries-detecting intraoral photographs*,
- Copy of treatment plan. Note: A completed ADA claim form submitted for an authorization is considered to be the treatment plan,
- Narrative describing medical necessity for hospital services.

* On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intraoral photographs to be made in the dental office setting. If this occurs, it must be noted in the patient record and on the TennCare Inpatient and Outpatient Hospital Readiness Pre- admission form (see Appendix A of this manual for required form). However, once the patient is sedated in a medical facility, appropriate diagnostic radiographs and/or intraoral photographs must be made to satisfy the authorization/ medical necessity requirements. Dentists who "routinely" fail to submit radiographs or intraoral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion.

DentaQuest will review prior authorization treatment plans submitted to determine the medical necessity for dental treatment in a medical facility. The preauthorization of dental treatment will be processed by DentaQuest.

DentaQuest will coordinate with the MCO as necessary. Please note that DentaQuest is not responsible for paying facility or related anesthesia charges associated with the provision of covered services that are medically necessary performed in an inpatient, outpatient or free-standing ambulatory surgical center. DentaQuest shall provide a prior authorization number to such Providers for inclusion on a UB-92 or HCFA 1500, as applicable, that shall be submitted
directly to the Member's MCO.

Non-emergency hospitalization is appropriate in the following situations:

- Documentation of psychosomatic disorders that require special handling. Young children requiring extensive operative procedures such as multiple restorations, abscess treatments, or oral surgical procedures may be eligible for hospitalization if prior authorization documentation indicates in-office treatment (conscious sedation/nitrous oxide) is not appropriate and

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hospitalization is not solely based upon reducing, avoiding or controlling apprehension. Cognitively disabled individuals where prior history indicates hospitalization is appropriate.

- Hospitalized individuals who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.
- Other medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures.
- A medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment not medically acceptable.
- A medical history of uncontrolled diabetes, in a situation where oral and maxillofacial surgical procedures are being performed.

Please note that a physician's written authorization is required if hospitalization is requested for an institutionalized individual.

4.2 Participating Hospitals and Surgery Centers

Upon approval, participating dentists are required to administer services at the Member's MCO's participating hospitals when services are not able to be rendered in the dental office. Participating dentists routinely bringing cases to medical facilities should obtain privileges at multiple facilities.

Participating Hospitals may change. Please contact plan for current listing.

BlueCare and TennCare Select: https://bluecare.bcbst.com/

UnitedHealthcare Community Plan:
https://www.uhccommunityplan.com/tn/medicaid/community-plan

Amerigroup: https://www.myamerigroup.com/tn/home.html

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DentaQuest

5.0 Claim Submission

DentaQuest strongly encourages all contracted Providers to submit claims electronically.

DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website (http://www.dentaquestgov.com/).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D IB_5010 File.
- Paper ADA approved dental format

5.1 Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 855-390-6424.

Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry." The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations at 800.417.7140 or via e-mail at: EDITeam@greatdentalplans.com

5.2 Electronic Attachments

A. FastAttach™

DentaQuest accepts dental radiographs electronically via FastAttach™ for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and remittance advice.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior

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authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea- fast.com or call NEA at: 800.782.5150

B. OrthoCAD™

DentaQuest accepts orthodontic models electronically via OrthoCAD™ for authorization requests. DentaQuest allows Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. OrthoCAD™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged models and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for OrthoCAD™ go to www.orthocad.com or call OrthoCAD™ at: 800.577.8767

5.3 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and

Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

Please note *Place of Service* is a required field on the ADA claim form. Claims not specifying *Place of Service* will be denied.

5.4 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

5.5 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards, and increase the accuracy and efficiency of claims administered by DentaQuest.

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- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/#/ and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

5.6 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. *Place of Service* is a required field on the ADA claim form. Claims not specifying *Place of Service* will be denied. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

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Claims should be mailed to the following address:

DentaQuest – TennCare Claims
PO Box 2906
Milwaukee, WI 53201-2906

5.7 Coordination of Benefits

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

5.8 Filing Limits

Participating Provider shall have no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file an initial claim with DentaQuest except in situations regarding coordination of benefits or subrogation in which case the Provider is pursuing payment from a third party or if an Member is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that DentaQuest receives notification from TennCare of the Member's eligibility.

In the event that a provider has a filed a claim within the required 120 day filing period, but the claim is denied as a result of administrative guidelines such as: missing documentation, Member eligibility status, missing claim details, the claim may still be considered for reimbursement. Upon receipt of the missing information or change in Member status DentaQuest will reconsider the claim denial if the initial filing timeline can be verified as occurring within the required 120 filing period and the additional information received is sufficient to meet payment guidelines. In this scenario, DentaQuest will honor the initial filing date and process the claim accordingly. Please note ** DentaQuest's system will not automatically override the filing limits, therefore, a provider must contact DentaQuest provider services to assist with the handling of the claim to ensure that it does not deny for untimely filing.

5.9 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department at 855-418-1623 with any questions you may have regarding claim submission or your remittance. Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

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5.10 Electronic Funds Transfer EFT (Direct Deposit)

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form found on the website.
- Attach a voided check to the form. The authorization cannot be processed without a voided check.
- Return the Direct Deposit Authorization Form and voided check to DentaQuest:

Via Fax:
262.241.4077
Or
Via Mail:
DentaQuest – TennCare PO Box 2906
Milwaukee, WI 53201-2906
ATTN: PDA Department

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork.
Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as changes in routing or account numbers or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Dentist Portal. Providers may access their remittance statements by following these steps:

1. Go to www.dentaquestgov.com
2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search."
5. The remittance will display on the screen.

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5.11 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, and/or the Division of TennCare[SM] harmless for the payment of non-covered Services except as provided in this paragraph.

Providers may bill a Member for non-covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- the services to be provided;
- DentaQuest and/or the Division of TennCare[SM] will not pay for or be liable for said services; and
- Member will be financially liable for such services.

If you reach an agreement to bill a Member for a non-covered service, do not submit the claim to DentaQuest. Submission of such services will render the arrangement with the Member null and void.

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6.0 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.
DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider agreements to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.
In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 855-418-1623 or via e-mail at denelig.benefits@dentaquest.com.

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DentaQuest

7.0 Appeals and Grievances

DentaQuest adheres to State, Federal, and TennCare℠ requirements related to processing grievances and appeals.

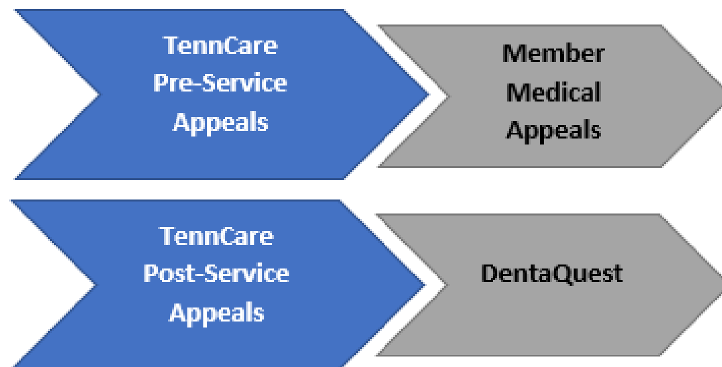
Note:

- Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 855-418-1623.
- A copy of the *Provider Dental Appeal Form* can be found in Appendix A of this manual.
- A copy of the *Member Dental Appeal Form* can be found in Appendix A of this manual.

There is a distinction between a Provider's appeal filed on provider's own behalf and a Member appeal filed by Provider on Member's behalf.

In order to file a request for a State Fair Hearing (TennCare Appeal) on Member's behalf, the Provider must first obtain the Member's signed and written authorization in accordance with 42 CFR

Appeals Process:



Pre-Service Appeals:

Who can file a pre-service appeal?

- The *provider* on behalf of the enrollee (with written permission);
- A *guardian* on behalf of the enrollee; or
- The *enrollee* themselves

How is an appeal filed?

Appeals must be filed to **TennCare Member Medical Appeals** within 60 days of receipt of the denial from DentaQuest

- Appeals can be filed in any of the following ways:

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- Mail:
  TennCare Member Medical Appeals
  PO Box 000593
  Nashville, TN 37202-0593
- Phone: (800) 878-3192
- Fax: (888) 345-5575

- Only the member will be notified of the determination by TennCare Member Medical Appeals.
- However, if TennCare Member Medical Appeals requests a redetermination from DentaQuest, a new PDL will be sent to the provider's office.
- Do not file pre-service appeals to DentaQuest or on the DentaQuest portal. These must be mailed or faxed directly to TennCare Member Medical Appeals.

Post-Service Appeals:

Who can file a post service appeal?
- Only the *provider* can file a provider appeal

How is an appeal filed?

- Appeals must be filed within 60 days of the original determination
- Appeals can be filed in any of the following ways
  - Mail:
    DentaQuest Provider Appeals
    PO Box 2906
    Milwaukee, WI 53201-2906
  - Via Provider Web Portal (most efficient)
  - Phone: (800) 878-3192
  - Fax: (888) 345-5575
- Successful appeals will be automatically approved

7.1 Member Appeal Process

The TennCare Member appeals process is governed by federal law and must meet CMS requirements. TennCare members have the right to request a State Fair Hearing to contest DentaQuest's adverse benefit determinations. For example, when DentaQuest denies a prior authorization request from one of its network providers for a TennCare-covered dental service, the denial constitutes an *adverse benefit determination* against the member.

When DentaQuest makes an adverse benefit determination against the member (for example, by denying provider's request for a dental service requiring prior authorization), DentaQuest must supply the member with a written *Notice of Adverse* Benefit Determination. The *NABD* explains to the member in plain English the legal and factual bases for the DentaQuest denial. The NABD will also specify the identity of the provider who requested the denied service and will instruct the member how to file an appeal with TennCare contesting the denial. If a provider receives a notice from DentaQuest advising that provider's prior authorization request has been denied, the TennCare member will have also received the *NABD* that details the member's appeal rights.

In the event that a dental service prior authorization request is denied by DentaQuest,

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the TennCare member has the right to appeal the denial to TennCare. With the member/member parent or guardian's signed and written authorization, a provider may file a TennCare service appeal on the member's behalf. The NABD instructs how to file such an appeal with TennCare either over the telephone or in writing.

Once a member appeal is filed, TennCare will conduct a review to determine both (i) whether the request comprises an appealable issue and (ii) whether the request should have been approved by DentaQuest. If TennCare determines that the services should have been approved, it will instruct DentaQuest to approve provision of the service and to notify the treating provider and the member of the approval. If TennCare agrees with DentaQuest's denial decision, the member will receive a hearing before an administrative judge. The member's treating provider may testify on behalf of the member at the hearing. If the hearing process results in a decision overturning DentaQuest's denial, DentaQuest will be instructed by TennCare to approve provision of the service.

PLEASE NOTE:

The TennCare member appeals process does not handle provider issues which have not resulted in an adverse action affecting the TennCare member's receipt of a benefit. For example, payment disputes between the provider and DentaQuest must NOT be filed as TennCare member appeals. If resolution of the issue under dispute does not affect whether the *TennCare member* will receive a service (or reimbursement of a service), then the appeal should be filed as a Provider Appeal See section 7.02 for an explanation of the Provider Appeal process.

TennCare Member Appeal of Service Denial

What?

Filed to contest DentaQuest's denial of:

Provider's prior-authorization request of a TennCare service

Example: Member files appeal after DentaQuest denies Provider's PA request for:

- Orthodontia
- Fixed prosthodontics
- Extractions
- Anesthesia
- Oral surgery

By Whom?

- By the Member or Member's parent/guardian
- By the Treating Provider (with Member's signed authorization).

Where?

TennCare Member Medical Appeals

By mail:

TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593

By phone:

Phone: 800.878.3192

By fax:

Fax: 888.345.5575

When?

- After DentaQuest has denied a PA (or member's reimbursement request)for a TennCare service
- Must be filed within **60** days of from the date on the adverse

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benefit determination notice issued to Member by DentaQuest

Rights and Responsibilities Regarding Member Appeals

TennCare members have the right to appeal any benefit determinations made by DentaQuest.
An *adverse benefit determination* is defined to include the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.

Appeals involving denials of authorizations for care for TennCare members may be lodged by the member or by anyone (**including the treating provider**) acting on the member's behalf and with member's signed, written authorization (which must be supplied to TennCare when the appeal request is filed) Dental providers play an important role in the appeal process for TennCare members. Among providers' responsibilities is the obligation to supply TennCare or DentaQuest with those medical and dental records necessary to substantiate the member's appeal.

Providers are also expected to perform the following functions during the TennCare member appeal process:

- Assist members by providing appeal forms and contact information including the appropriate procedures for requesting a State Fair Hearing (TennCare Appeal). A copy of the TennCare member appeal form and the requisite Member authorization form for filing an appeal on member's behalf have been included in this ORM.
- Seeking prior authorization for those dental services which are subject to the pre-authorization requirement.
- Providing medical records as needed within TennCare Appeal timeframes, as communicated by DentaQuest at the time of appeal.
- Conspicuously display a copy of the Notice of Appeal Rights poster. This Notice describes a TennCare member's right to appeal a benefit determination affecting services. A copy of the Notice of Appeal Rights poster has been included in the ORM. DentaQuest shall ensure no punitive action is taken against a provider who files an appeal on behalf of a member (with the member's, member's parent, or member's guardian's signed and written consent), or supports a member's. DentaQuest does not prohibit or discourage anyone from testifying on behalf of a member.

Medical Records

Resolution of a member service appeal in favor of the member often hinges on whether the service being appealed is found to be medically necessary under the TennCare Medical Necessity Rule. Providers can help to speed up the appeal process by making sure that medical records are always included with the appeal submission. If the

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member files an appeal without including the applicable records in support of the appeal, DentaQuest or TennCare will contact you for copies of the records. Please forward any medical records requested as quickly as possible, due to the short timeframes mandated by federal law. No release form is needed, as the TennCare member has agreed to release of medical records as a condition of their participation in the TennCare program.

7.2 Provider Appeal Process (Post-Service Appeals)

Providers have multiple options to appeal a decision post-service.

Participating Providers that disagree with claims processing determinations made by DentaQuest may submit a written notice of disagreement to DentaQuest that specifies the nature of the issue. The Provider Appeal form, located in Appendix A-9, can be used for this purpose. The appeal must be sent within 60 days from the date of the original determination.

TennCare Provider Appeal of Claim Denial

What?

Filed to contest DentaQuest's denial of:

- Provider's payment of a TennCare claim

By Whom?

By the Provider (the member has already received the service)

Where?

DentaQue
st ***By***
mail:

DentaQuest - TennCare PO Box 2906
Milwaukee, WI 53201-2906
Attn: Appeals & Grievances Department

By fax:

Fax: 262.834.3452

Through the web portal:
https://govservices.dentaquest.com/ - Registered users can go to Tools and select Contact DentaQuest

When?

- After DentaQuest has denied a provider's TennCare claim
- Must be filed within **60** days of receiving DentaQuest's denial

All provider appeals received timely by DentaQuest will be reviewed by the Complaints and Grievances department for review and reconsideration, which includes review by a clinical professional. The department will respond in writing with its decision to the Provider.

Tennessee Department of Commerce and Insurance Complaint Process

The TDCI Provider Complaint process is a courtesy provided to dental providers who have a complaint against DentaQuest. This process is free.

Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from DentaQuest, miscommunication or confusion around DentaQuest policy and procedures, etc.

When a provider complaint is received, the TennCare Oversight Division will forward the complaint to DentaQuest for investigation. DentaQuest is required to respond in

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writing to both the provider and the TennCare Oversight Division by a set deadline to avoid assessment of liquidated damages or other appropriate sanction.

If the provider is not satisfied with DentaQuest's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to,

requesting a claims payment dispute be sent to an Independent Reviewer for resolution or pursuing other available legal or contractual remedies.

Provider complaints can be submitted by completing the electronic **form for TennCare Provider Complaints** and submitting it by fax or mail to the fax or mail address listed below.

Fax Number:

(615) 401-6834

Mailing Address:

Tennessee Department of Commerce & Insurance
TennCare Oversight Division

500 James Robertson Parkway, 11th floor
Nashville, TN 37243-1169

Instructions and current copies of the forms can be obtained on the state's Web site at https://www.tn.gov/commerce/tenncareoversight.html

TDCI TennCare Provider Independent Review of Disputed Claims

In addition to the above process, Providers may file a request with the

Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process.

The Independent Review process was established by statute (Tennessee Code Annotated § 56-32-126(b)(2)) to resolve claims disputes when a provider believes a TennCare managed care company such as DentaQuest has partially or totally denied claims incorrectly. A failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within sixty (60) days of DentaQuest's receipt of the claim is considered a claims denial.

The TennCare Oversight Division administers the independent review process but does not perform the independent review of the disputed claims. When a request is received, the TennCare Oversight Division determines that the disputed claims are eligible for independent review based on the statutory requirements (i.e. the disputed claims were submitted for independent review within 365 days from the date the MCC's first denied the claims). If the claims are eligible, the TennCare Oversight Division forwards the claims to a reviewer that is not a state employee or contractor and is independent of the MCC and the provider. The decision of the independent reviewer is binding unless either

party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.

There is a $750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCC is responsible for paying the fee.

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Conversely, if the independent reviewer finds in favor of the MCC, the provider is responsible for paying the fee.

The independent review process is only one option a provider has to resolve claims payment disputes with a TennCare MCC. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

7.3 Member Complaints

DentaQuest's process for handling Member Complaints against Providers and/or DentaQuest is as follows:

- The Member Complaint process shall only be for Complaints as defined in Section 16.00. DentaQuest and the Providers shall ensure that all Member Appeals, as defined in sections 7.00 through 7.02, are addressed through the Appeals process, rather than through the Complaint process.
- DentaQuest and the Provider shall allow a Member to file a Complaint either orally or in writing at any time.
- Provider shall forward a copy of any written Member Complaint the Provider receives to DentaQuest within one (1) business day of receipt from Member. Provider shall forward to DentaQuest a full and complete written version of any Complaint received orally from a Member within one (1) business day of receipt from Member. All such transmissions of Member Complaints to DentaQuest shall be made electronically, via secure email or facsimile transmission.
- Within five (5) business days of receipt of the Complaint, DentaQuest shall provide written notice to the Member and the Provider (if the Complaint was against the Provider) that the Complaint has been received and the expected date of resolution. However, if DentaQuest resolves the Complaint and verbally informs the Member, and Provider if appropriate, of the resolution within five (5) business days of receipt of the Complaint, DentaQuest shall not be required to provide written acknowledgement of the Complaint to the Member, and Provider if appropriate.
- DentaQuest shall resolve and notify the Member and the Provider (if the Complaint was against the Provider) in writing of the resolution of each Complaint as expeditiously as possible but no later than thirty (30) days from the date the Complaint is received by DentaQuest. The notice shall include the resolution and the basis for the resolution. However, if DentaQuest resolved the Complaint and verbally informed the Member and Provider, if appropriate, of the resolution within five (5) business days of receipt of the
- Complaint, DentaQuest shall not be required to provide written notice of resolution to either the Member or the Provider (if the Complaint was against the Provider).
- DentaQuest and Providers shall assist Members with the Complaint process.
- DentaQuest shall resolve each Member Complaint with assistance from the affected Provider, as needed, and Provider shall comply with DentaQuest's request for assistance. The resolution process includes various methods of determining the cause of, and the appropriate resolution of, a Complaint, including, but not limited to, use of a corrective action plan (CAP). A CAP is a plan to correct Provider's noncompliance with the Provider Agreement (including noncompliance resulting in Member Complaints) that the Provider

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prepares on his/her own initiative, or at DentaQuest's request, to submit to DentaQuest for review and approval. Provider shall respond timely to the CAP request and take all CAP actions that have been approved by

DentaQuest. Failure to comply with a request to provide a CAP or the terms and conditions of an approved CAP may result in actions against the Provider, including termination of the affected Provider's Provider Agreement by DentaQuest. The various components of a CAP are as follows:

- *Notice of Deficiency*: If DentaQuest determines that the Provider is not in compliance with a requirement of the Provider Agreement (including, but not limited to, issues relating to a Member's Complaint) DentaQuest will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Provider intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to DentaQuest and may also contain recommendations or requirements the Provider must include or address in the CAP.
- *Proposed CAP:* Upon receipt of a Notice of Deficiency, the Provider shall prepare a proposed CAP and submit it to DentaQuest for approval within the time frame specified by DentaQuest. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.
- *Approved CAP Implementation*: DentaQuest will review the proposed CAP and work with the Provider to revise it as needed. Once approved, the Provider shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the CAP, to DentaQuest's satisfaction.
- *Notice of Completed CAP*: Upon satisfactory completion of the implemented CAP, DentaQuest shall provide written notice to the Provider. Until written approval is received by the Provider, the approved CAP will be approved CAP will be deemed to not havebeen satisfactorily completed.

- DentaQuest shall track and trend all Member Complaints, timeframes and resolutions and ensure remediation of individual and/or systemicissues.
- Upon request, DentaQuest shall submit reports regardingMember Complaints to TennCare.
- Member Complaints pertaining to discrimination shall be handled in accordance with the separate Nondiscrimination process outlined in this manual in Section 1.01.

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8.00 Fraud and Abuse

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care It also includes Member practices that result in unnecessary cost to the Medicaid program

Member Fraud: If a Provider suspects a Member of ID fraud, drug-seeking behavior, or any other fraudulent behavior, it should be reported to DentaQuest or TennCare.

TennCare Fraud Hotline: 800.433.3982

You can find more information about reporting fraud and abuse at https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html

Reporting directly to DentaQuest:
DentaQuest- TennCare Dental Plan
Attention: Utilization Review Department
PO Box 2906

Milwaukee, WI 53201-2906
Toll free at 855-418-1623

8.1 Policies and Procedures

False Claims Act Information

Purpose

To provide information about the False Claims Act (the "FCA") and related legal requirements as required by the Deficit Reduction Act of 2005.

Policy
It is the policy of DentaQuest to provide service in a manner that complies with applicable federal and state laws and that meets the high standards of professional ethics. To further this policy DentaQuest provides the following information about the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

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1. Federal False Claims Laws

The FCA, 31 U.S.C. §§ 3729-2733, imposes liability on any person or entity who knowingly files an unjustified or false claim for payment to Medicare, Medicaid or other federally funded health program.

"Knowingly" means that a person has actual knowledge that the information on the claim is false; acted in deliberate ignorance of whether the claim is true or false; or acted in reckless disregard of whether the claim is true or false.

A person or entity found liable under the FCA is, generally, subject to three times the dollar amount that the government is defrauded and penalties of

$5,500 to $11, 000 for each false claim. If there is a recovery in the case brought under the FCA, the person bringing the suit may receive a percentage of the recovery. For the party found responsible for the false claim, the government may seek to exclude it from future participation in Federal healthcare programs or impose additional obligations against it.

2. Anti-Retaliation Protection

DentaQuest encourages personnel to report any concerns relating to potential fraud and abuse, including false claims.

The FCA states that no person will be subject to retaliatory action as a result of their reporting of credible misconduct.

Pursuant to DentaQuest's compliance with the FCA and other applicable DentaQuest policies and procedures, no team Member will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by DentaQuest solely because of actions taken to report potential fraud and abuse or other lawful acts by the team Member in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

3. Anti-Fraud Hotline

The Anti-Fraud hotline can be accessed by calling 800.433.3982. We investigate all incoming calls to determine if the allegations are warranted. Based upon the information received from callers, the proper course of action is determined.

4. Monthly Screening requirement

For the purpose of the Monthly Screening Requirements, the following definitions shall apply:

"Exclusion Lists" means the U.S. Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities (located at http://www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at http://www.epls.gov).

"Ineligible Persons" means any individual or entity who: (a) is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42

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U.S.C. § 1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their monthly obligation to screen all employees and contractors (the "Monthly Screening Process") against the Exclusion Lists to determine whether any of them have been determined to be ineligible Persons, and therefore, excluded from participation as a Medicaid Provider. Providers are also required to have employees and contractors disclose whether they are Ineligible Persons prior to providing any services on behalf of the Provider. The Monthly Screening Process is a Centers for Medicare & Medicaid Services (CMS) requirement and a condition of their enrollment as a DentaQuest Medicaid Provider and is also a continuing obligation during their term as such.

Medicaid Providers must immediately report any exclusion information discovered to DentaQuest.

If Provider determines that an employee or contractor is or has become an Ineligible Person, Provider will take the appropriate action to remove such employee or contractor from responsibility for, or involvement with Provider's operations related to Federal health care programs. In such event, the Provider shall take all appropriate actions to ensure that the responsibilities of such employee or contractor have not and will not adversely affect the quality of care rendered to any DentaQuest Member of

any Federal health care program.

5. Credible Allegation of Fraud

Pursuant to Federal law at 42 CFR 455.23 the Division of TennCare may direct DentaQuest to suspend payments to a Provider where the TennCare Division has made a determination that there is a credible allegation of fraud against the provider that is currently under investigation. In the event of such a suspension the Provider must work directly with the Division of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Division of TennCare.

6. Other Program Integrity Actions

DentaQuest is required in its contract to report suspected cases of Provider fraud and abuse to TennCare. In addition, TennCare conducts its own independent Program Integrity functions. In the event that a provider is contacted by the Bureau of TennCare concerning a Program Integrity matter, the Provider must work directly with the Division of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Division of TennCare.

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9.0 Quality Improvement Program (QIP)

DentaQuest maintains a comprehensive Quality Improvement/Management Program to objectively monitor and systematically evaluate the care and service provided to Members. The program is modeled after National Committee for Quality Assurance (NCQA) standards; the NCQA standards are adhered to as the standards apply to dental managed care. In addition, DentaQuest's Quality Improvement Program is in compliance with TennCare[SM] guidelines. The scope and content of the program reflects the demographic and epidemiological needs of the population served.

The written Quality Management Program (QMP) Description clearly defines quality improvement structures, processes, and related activities to facilitate identification of opportunities for improvement on an ongoing basis.

In conjunction with the QMP Program Description, DentaQuest develops and maintains an Annual Work Plan that identifies QMP activities, yearly objectives, time frames for completion, and persons responsible for oversight of QMP activities and objectives. The QMP Work Plan is considered a dynamic document that is updated on an on-going basis, as indicated. DentaQuest also conducts Performance Improvement Projects in accordance with TennCare requirements.

DentaQuest uses the results of QMP activities to improve the quality of dental health in association with appropriate input from providers and Members. The evaluation of the QMP addresses Quality Monitoring studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. This quality survey will be released annually to the provider network. Each provider will get specific notification.

The Quality Improvement Program includes:

- Provider Credentialing and Recredentialing
- Member Satisfaction Surveys
- Provider Satisfaction Surveys
- Random Chart Audits
- Member Appeal Monitoring and Trending
- Peer Review Process
- Utilization Management and Practice Patterns
- Site Reviews and Dental Record Reviews
- Patient Safety
- Service Initiatives
- Compliance Monitoring

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- Quarterly Quality Indicator Tracking (i.e. Member appeal rate, appointment waiting time, access to care, etc.)

The QIP includes both improvement and monitoring aspects, and requires the ongoing process of:

Responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

Assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.

The QMP also includes written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not furnished.

DentaQuest maintains a comprehensive committee structure with oversight from the governing body to facilitate quality monitoring program activities.

Quality Monitoring Program Committee:

The purpose of the Quality Management Committee is to maintain quality as a cornerstone of the DentaQuest culture and to be an instrument of change through demonstrable improvement in care and service. The QMP Committee Is accountable to DentaQuest's Governing Body, which approves the overall QMP, Work Plan, and Annual Evaluation. The Committee analyzes and evaluates the results of QMP activities, recommends policy decisions, ensures that providers are involved in the QMP, institutes needed action, and ensures that appropriate follow-up occurs.

Provider Peer Review Committee

DentaQuest maintains a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. This Committee meets regularly to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers.

A copy of DentaQuest's QI Program is available upon request by contacting DentaQuest's Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com.

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10.00 Credentialing

DentaQuest and TennCare℠ have the sole right to determine which dentists (DDS or DMD), they shall accept and allow to continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, monitoring, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry and is in full compliance with TennCare℠ guidelines.

Nothing in this Credentialing Plan limits DentaQuest's discretion to accept or discipline Participating Providers. No portion of this Credentialing Plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement instead of this Credentialing Plan.

DentaQuest must credential each provider location and DentaQuest is not required to credential all of a provider's locations.

DentaQuest and TennCare℠ have the final decision-making power regarding network participation. DentaQuest will notify TennCare℠ of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendation.

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by DentaQuest within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers

Procedures for Discipline and Termination

Recredentialing

Network Providers are recredentialed at least every 36 months pursuant to TennCare℠ guidelines.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com

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11.00 The Patient Record

Participating Providers are required to maintain proper patient records.

11.1 Accessibility and availability of Dental Records

Corrections/Alteration Protocols:

There are times when it is necessary to make a correction to a patient record; this need to make corrections should be an exception not a pattern. Any corrections, late entries, entries made out of sequence and addenda made in a patient record should be clearly marked as such in the record. A single line should be drawn through any erroneous chart entry and the word “error” should be noted; the correct treatment should be noted with the correct treatment referenced and these corrections should be signed and dated. In incidents where correction or alterations would need to be completed on a later date, the addenda and/or corrected treatment information should be entered “chronologically and refer to the date of visit in question

According to the American Dental Association Council on Dental Practice Division of Legal Affair publication” Dental Records” published in 2010:

- Cross out the wrong entry with a thin line and make the appropriate change;
- Date and initial each change or addition;
- Never obliterate an entry with markers or white-out, as you and/or athird party must be able to read the wrong entry;
- Do not leave blank lines between entries;
- Do not insert words or phrases in an entry;
- If a correction needs to be made at a later date, enter the correction chronologically but reference the date in question that you are correcting.

According to CMS Program Integrity2:
Any record that contains delayed entries, amendments, corrections or addenda must be:

- Clearly and permanently identify any amendment, correction or delayed entry as such; and
- Clearly indicate the date and author of any amendment, correction, or delayed entry, and;
- Not delete but instead clearly identify all original content.”
- Corrections, amendments or delayed “entries to paper records must be clearly signed and dated upon entry in the record.”
- American Dental Association Dental Records – 2010
- CMS Manual System Pub 100-08

11.2 Recordkeeping

Dental Record Standards – DentaQuest sets standards for dental records. These standards shall, at a minimum, include requirements for:

a. Member Identification Information - Each page in the record contains the patient's name or enrollee ID number.

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b. Personal/biographical Data - Personal/biographical data includes age; gender; address; employer; home and work telephone numbers; and marital status.

c. Entries - All entries are dated on the day of service. Entries shall detail services provided and be signed by the rendering provider

d. Provider Identification - All entries are identified as to author.

e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.

f. List of current medications.

g. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location.

h. Past Medical History - (for Members seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For orthodontics requested secondary to speech pathology, obtain speech/language

i. records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency. For children, past medical history relates to prenatal care and birth.

j. Immunizations - (for pediatric records ages 12 and under) There is acompleted immunization record or a notation that immunizations are up to date.

k. Diagnostic information. When submitting claims for services other than preventive or diagnostic services patient record must contain one or more of the following: radiographs, intraoral photos, charting of pathology, narrative in chart notes that includes reasoning for service. This is necessary to determine medical necessity.

l. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

m. Documentation of medical necessity of all procedures, including but not limited to sedation/anesthesia procedures and signed copies of consent forms

n. Tobacco Use - (For Members 12 years and over and seen three or more times) Notation concerning tobacco use is present. Abbreviations and symbols may be appropriate.

o. Referrals and Results Thereof

p. Emergency Care.

q. Compliance with Tennessee Board of Dentistry Rule 0460-02-.12 Substance abuse and mental health treatment information (behavioral health records) – Records shall be kept separate and apart from the medical record in compliance with federal law.

Patient Visit Data – Documentation of individual encounters must provide adequate evidence of, at a minimum:

a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.

b. Plan of Treatment.

c. Diagnostic Tests.

d. Therapies and other Prescribed Regimens.

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e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

f. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment.

g. All Other Aspects of Patient Care, Including Ancillary Services.

h. Documentation of sedation (please see section 15.09).

Record Review Process

a. DentaQuest has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.

b. The record assessment system addresses documentation of the items listed in the Patient Visit Data section above.

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12.0 Patient Recall System Requirement

Participating Providers are required to maintain proper patient records.

A. Recall System Requirement

Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any TennCare[SM] Member that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teethhealthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that TennCare[SM] patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate. Please note that Members cannot be charged for missed appointments.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supportedscreening program, contact staff from these programs to ensure that scheduled appointments are kept.
- Have the Member contact the provider's office prior to the appointment to confirm the time and place of the appointment.

B. Office Compliance Verification Procedures

DentaQuest will measure compliance with the requirement to maintain a patient recall system. Participating Providers are expected to meet minimum standards regarding appointment availability:

- Emergency care must be appointed within 24 hours and is defined as an unscheduled episode that requires a service to patients who present for immediate attention. The condition, if untreated, could place the patient's health in jeopardy or cause serious consequences.
- Urgent care, those involving pain, infection, swelling and/or traumatic injury, must be available within 48 hours.
- DentaQuest ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member's treating dentist, other dental professional, primary care provider or triage nurse who is trained in dental care and oral healthcare.

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- Initial and recall routine treatment must be scheduled within 21 days of initial contact with the dentist's office.
- Follow-up appointments must be scheduled within 21 days of the present treatment date. DentaQuest requires that a patient be seen within 45 minutes of arriving at the office or be given the opportunity to reappoint.
- Participating Providers unable to meet these guidelines must refer the Member back to DentaQuest. DentaQuest will then be responsible for arranging needed care in the appropriate time frames. The number for Members to call for assistance is:
  855.418.1622 for TennCare[SM] Members

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13.00 Radiology Requirements

DentaQuest recommends that you submit your attachments and x-rays through an electronic attachment service.

When mailing x-rays for authorization with the claim, **ALWAYS SUBMIT A DIAGNOSTIC QUALITY DUPLICATE OF THE X-RAY.** X-rays **WILL NOT** be returned unless a stamped, self-address envelope is attached to the request.

Guidelines for Prescribing Dental Radiographs

Type of Encounter	**Child with Primary Dentition** (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first-permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult Dentition or Partially Edentulous**	**Adult, Edentulous**
New Patient being evaluated for dental diseases and dental development *	Individualized radiographic exam consisting of selected periapical/ occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.

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Type of Encounter	**Child with Primary Dentition** (prior to eruption of first permanent tooth) disease and with open proximal contacts may not require a radiographic exam at this time.	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult Dentition or Partially Edentulous**	**Adult, Edentulous**
Recall patient* with clinical caries or at increased risk for caries **	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries **	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing	Usually not indicated	

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Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/ endo dontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.

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14.0 Health Guidelines

In the event that TennCare rules or DentaQuest clinical criteria conflict with any of the following Periodicity Recommendations, then such TennCare rules or DentaQuest clinical criteria shall control.

	Infancy 6-12 Months	Late Infancy 12-36 Months	Preschool 3-5 Years	School Aged 6-12 Years	Early Adolescence 13-15 Years	Late Adolescence
Oral hygiene counseling (1)	Parents, Caregivers	Child, Parents, Caregivers	Child, Parents, Caregivers	Child, Parents, Caregivers	Patient	Patient
Injury prevention counseling (2)	X	X	X	X	X	X
Dietary counseling (3)	X	X	X	X	X	X
Counseling for non-nutritive habits (4)	X	X	X	X	X	X
Fluoride supplement-ation (5)	Systemic and topical	Systemic and topical	Systemic and topical	Systemic and topical	Topical	Topical
Access oral growth and develop-ment (6)	X	X	X	X	X	X
Clinical oral exam every 6 months	First exam before the age of 12 months	X	X	X	X	X

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	Infancy 6-12 Months	Late Infancy 12-36 Months	Preschool 3-5 Years	School Aged 6-12 Years	Early Adolescence 13-15 Years	Late Adolescence
Prophylaxis and topical fluoride treatment every 6 months	Age appropriate cleaning and fluoride	X	X	X	X	X
Evaluation of periodontal health		X	X	X	X	X
Radiographic assessment (7)	As Needed	As Needed	X	X	X	Panorex to check third molars
Pit and fissure sealants (8)				1st Permanent molars as soon as possible after eruption	1st Permanent molars as soon as possible after eruption	
Treatment of dental	X	X	X	X	X	X
Assessment and treatment of developing malocclusion (9)			X	X	X	X
Substance abuse counseling (10)				X	X	X
Assessment and removal of 3rd molars (11)						Removal if symptomatic
Referral for regular periodic dental care	X	X	X	X	X	X
Anticipatory guidance	X	X	x	X	X	X

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1. Initially, responsibility of parent as child develops jointly with parents, then when indicated only by child. 2. Initially play objects, pacifiers, car seats, then when learning to walk, and finally sports and routine playing. 3. At every appointment discuss role of refined carbohydrates, moderation of fat intake, frequency of snacking. 4. At first discuss need for additional sucking (digits vs pacifiers) when needed to wean from habit before eruption of first permanent front teeth. 5. As per AAPD/ADA guidelines and the water source. 6. By clinical examination. 7. As per FDA radiographic guidelines. 8. Bicuspids should be examined for medical necessity. 9. Please refer to orthodontic criteria in Section 15.13. 10. To include alcohol, tobacco, and smokeless tobacco. 11. Please refer to Section 15.1. 12. Appropriate discussion and counseling should be an integral part of each visit for caries.

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15.0 Clinical Criteria

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. Failure to submit required documentation when requesting authorization for a service may result in a denial by DentaQuest. DO NOT FILE AN APPEAL, this will deny. All covered dental services must also be Medically Necessary as defined by TennCare Rules. The clinical criteria presented in Section 15.01 through 15.16 are the criteria that DentaQuest dental benefit reviewers will use for making medical necessity determinations for those specific procedures. In addition, please review the general benefit limitations for certain dental procedures presented in Exhibit

A. Exceptions to general benefit limitations may be made on an individual enrollee basis if medically necessary.

Failure to submit the required documentation may result in a disallowed request and denied payment of a claim related to that request. Prior authorization is required for orthodontic treatment, complex oral surgery procedures, endodontic treatment, prosthodontic treatment, and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center.

EMERGENCY Treatments and Authorizations
If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings. After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation.

Please FAX this to 262-241-7150.
DentaQuest will process emergency authorization requests as high priority. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

For all procedures, every Provider in the DentaQuest program is subject to random chart/treatment audits. These audits may occur in the Provider's office as well as in the office of DentaQuest. Based on the findings of any audit, the Provider will be notified of the results of the audit. In the event that audit findings require examination by the DentaQuest Tennessee Peer Review Committee, any requested records must be made available upon request to DentaQuest.

Whether a procedure requires prior authorization or not, all procedures require acceptable documentation standards be met. Documentation for all procedures rendered must justify the need for the procedure performed due to medical necessity.

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required.

Postoperative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that

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radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Failure to provide the required documentation, audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel. Additionally, the provider may be referred to the Division of TennCare for possible actions impacting the provider's ability to participate in the TennCare Medicaid, CoverKids, and other state Medicaid programs.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns is the cementation date. The completion date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Providers participating in the Division of TennCare networks with DentaQuest represent and warrant that all dental services shall be provided in a high-quality manner and on a timely basis. Using the proper skill set, training and background necessary to accomplish medically necessary treatment, rendered by competent providers who possess the skills necessary to perform the services with the degree of skill and care that is required by current good and sound procedures and practices in accordance with industry standards. Upon member request, if a treatment requires the provider to retreat due to quality, the expectation is the provider will do this as part of their standard office policies.

15.1 Criteria for Dental Extractions

Although all extractions must be medically necessary, not all procedures require authorization. Extraction of primary or permanent teeth in individuals under age 21 do not require authorization unless the teeth are unerupted third molar or residual tooth roots to be surgically removed. Removal of primary teeth whose exfoliation is imminent (coronal remnants) does not meet criteria for extraction and is not reimbursable.

Documentation needed for authorization procedure:

Diagnostic radiographs (strongly encourage digital) that are labeled Right (R) and Left

(L) and the date the radiographs were taken, not submitted, showing clearly the adjacent and opposing teeth submitted for authorization (whether prior or post service) review; bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when

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prior authorization (authorization prior to service) is not possible, will still require that appropriate radiographs be submitted with the claim for review for payment. This is considered retro authorization.

Authorization for extraction of unerupted third molars:

Benefit review decisions for the authorization of unerupted third molar tooth extractions will be based upon medical necessity. In other words, **providers must use the most current and appropriate ADA Code(s) on Dental Procedures and Nomenclature (CDT) when submitting either a prior- authorization or retro-authorization for unerupted third molar extractions.**

- The prophylactic removal of disease-free unerupted third molars is not considered medically necessary and, therefore, will not be authorized.
- Impaction alone, absent pathology does not meet medical necessity criteria and therefore will not be authorized.
- For an extraction to be considered medically necessary an unerupted third molar must show pathology, or
- An unerupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations **and** substantial (≥ 50%) root formation.
- Discomfort from natural tooth eruption not caused by pathology position will not qualify an unerupted third molar extraction for authorization.
- When at least a single third molar meets the criteria above, the DBM may, at its complete clinical discretion and on a case-by-case basis, approve the extraction of additional unerupted third molar teeth to avoid risk from multiple exposures of the member to anesthesia.
- Routine incision and drainage is not considered a separate benefit if the extraction serves in this function
- Excision of lesion in conjunction with extraction is considered part of the extraction procedure.
- Excision of lesion that is not tooth related on same date of service requires a narrative and radiographic documentation of a hard tissue cyst/lesion or photographic evidence of soft tissue cyst/lesion

Alveoloplasty in conjunction with extractions require:

- A minimum of 4 teeth removed in a quadrant to qualify for the code
- Narrative supporting necessity for prosthetic placement
- Treatment notes must indicate that an Alveoloplasty is a separate surgical procedure from tooth removal.

Alveoloplasty not in conjunction with extractions require:

- A minimum of 4 tooth spaces in a quadrant to qualify for the code
- Narrative supporting necessity for prosthetic placement
- Not allowed with extractions in same quadrant on same date of service.

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Surgical exposure of unerupted tooth to aid eruption or for orthodontic purposes:

- Radiographic evidence of impaction 1 year beyond normal age of eruption
- Tooth position that indicates tooth cannot erupt into the oral cavity
- Narrative of medical necessity
- Will be considered as part of another service if performed in conjunction with the removal of an adjacent unerupted tooth.

Tooth re-implantation:

- Must include a narrative indicating accident or trauma
- Must include a peri-apical radiograph
- Can only be reviewed retrospectively.

15.2 Criteria for Crowns

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth should be submitted for prior authorization or with the claim once service has been rendered;

  bitewings, periapicals or panorex.

- Appropriate diagnostic radiographs showing the completed restoration must be in the patient's record.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

Documentation required post service:

Clinically accepted standards of care REQUIRE post cementation/insertion radiographic evidence that all crowns have been completed. A post insertion radiograph is not required to be submitted but must be in patient's chart, and the quality of the restoration must be able to be confirmed by the radiograph. If a provider chooses to submit a post cementation radiograph, it is important to note that no additional reimbursement is allowed for post cementation radiographs. Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.

Criteria:

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations or where other restorative materials have a poor prognosis.
- Patients are eligible for crowns on teeth 3, 14, 19 and 30 at age 16.

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- Patients are eligible for crowns on teeth 2, 15, 18, and 31 at age 18.
- Patients are eligible for crowns on teeth (4-13; 20-29) at age 18.
- Permanent molar teeth should have destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth should have destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth should have destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- A request for a core build-up or a cast core must meet the following criteria:
    - Presence of greater than 50% bone support
    - Absence of sub-osseous decay and/or furcation involvement
    - Absence of tooth structure to support crown
    - Clinically acceptable root canal fill (post and core)

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the tooth.

Crowns on permanent teeth are expected to last a minimum of five years. Authorizations for crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent destruction due to caries or trauma.

15.3 Criteria for Endodontics

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be

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treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted showing properly condensed/obturated canal(s), for review for payment.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

Authorization for Pulpotomy must meet the following criteria:

- A pulpotomy is performed in a primary tooth with extensive caries but without evidence of radicular pathology when caries removal results in a carious or mechanical pulp exposure.
- A pulpotomy is indicated when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure. The objective is to maintain an asymptomatic tooth without clinical signs of sensitivity, pain, or swelling.

Authorization for Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for root canal therapy, root canal re-treatment, apicoectomies and apexification will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the toothnon-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- Filling material not accepted by the Federal Food and Drug Administration.

Other considerations:

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obturation of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service

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may be recouped after DentaQuest reviews the circumstances.

15.4 Criteria for Stainless Steel Crowns

- Prophylactic use of stainless steel crowns is not a covered benefit.

Although authorization for Stainless Steel Crowns are not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre-operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.
- Copy of patient's dental record* with complete caries charting and dental anomalies
- Copy of detailed treatment plan.

Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

Dental Records are regulated by the Rules of The Tennessee Board of Dentistry 0460-2-.11 Regulated Areas of Practice (5a and b).

Criteria:

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.
- Permanent molar teeth should have destruction to the tooth by caries or trauma and should involve four or more surfaces and/or two or more cusps.
- Permanent bicuspid teeth should have destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth should have destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary anterior teeth should have destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay.
- Primary molars should have destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay
- Primary teeth that have had a pulpotomy or pulpectomy performed.

Note: DentaQuest may require a second opinion or prior authorization for requests of more than 4 stainless steel crowns per patient.

Note: If a participating Provider fails to comply with the medical necessity guidelines for stainless steel crowns, DentaQuest will initiate corrective action, which may include imposition of prior authorization for this procedure.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

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- Should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless steel crowns on permanent teeth are expected to last five years.

Criteria for treatment using stainless steel crowns will not be met if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent destruction due to caries or trauma.

15.5 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU)

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In emergencies).

Providers must submit the following documents or review by DentaQuest for authorization of OR cases:

- Provision of dental in treatment in a hospital or SPU requires informed consent.
- Provision of dental treatment in OR for SPU requires prior authorization from DentaQuest unless such dental treatment constitutes an emergency. **Providers requesting PA for dental treatment in OR or SPU must submit the following documentation with their PA request** in order for DentaQuest to determine whether the PA request meets medical necessity and clinical criteria:
  - Completed TennCare Inpatient and Outpatient Hospital Readiness Preadmission Form. (see Appendix A-8 of this manual for required form) This form must evidence that the requesting dental provider attempted to treat the patient in-office and, where appropriate, referred the patient to a pediatric dentist or other specialist. Absent evidence of attempted in-office treatment and/or referral to pediatric dentist or other specialist, prior authorization may be denied by DentaQuest.
- Copy of the patient's dental record including health history, charting of the

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teeth and existing oral conditions*.

- Diagnostic radiographs or caries-detecting intra-oral photographs.
- Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.
- Narrative describing medical necessity for OR.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

† On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intra-oral photographs to be made. If this occurs, it must be noted in the patient record and narrative describing medical necessity. Dentists who "routinely" fail to submit radiographs or intra-oral photographs may be denied authorization for treatment

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

**Dental Records are regulated by the Rules of the Tennessee Board of Dentistry 0460-2-.11 Regulated Areas of Practice (5a and b).*

The provider is responsible for choosing facilities/providers from Member's MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient's primary care provider. DentaQuest would not recommend that providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.

Criteria:

In most situations, OR cases will be authorized for procedures covered by TennCare℠ if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in- office treatment (nitrous oxide, oral, IM, or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

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- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

15.6 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

Criteria:

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and majority of teeth must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- In general, a partial denture will be approved for benefits if it can be demonstrated that masticatory function has been severely impaired.

Authorizations for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and nonfunctional.
- If the patient has gingivitis or periodontal disease.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.

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- If the recipient cannot accommodate and properly maintain the prosthesis (lodge, gag reflex, potential for swallowing the prosthesis, severe disability).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Benefit Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion.
- Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are

  inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

After 6 months has elapsed:

- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
- Relines will be reimbursed once per denture every 36 months.
- A new prosthesis will not be reimbursed within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
- Replacement of lost, stolen, or broken dentures less than 5 years of age will not meet criteria for pre-authorization of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

15.7 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori is an appropriate course of treatment prior to prosthetic

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treatment.

CDT codes D7471, D7472, and D7473 are related to the removal of exostoses. These codes are subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Authorization requirements:

- Appropriate radiographs and/or intra-oral photographs and/or study models which clearly identify the exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Copy of detailed treatment plan– including prosthetic plan.
- Narrative of medical necessity, if appropriate.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

15.8 Criteria for the Determination of a Non-Restorable Tooth

DentaQuest will deny coverage for the services for patients 21 and over.

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth apex is surrounded by severe destruction of the bone.

15.9 Criteria for General Anesthesia, IV Sedation, and Anxiolysis *

Participating Providers who perform in office sedation must comply

with the rules and regulations established by the Tennessee Board of Dentistry as they apply to sedation. Failure of Providers to provide compliant documentation of sedation in the patient record will result in corrective action and recoupment of monies paid for non-compliant sedation.

Documentation needed for authorization of procedure:

- Diagnostic radiographs or intra-oral photographs
- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when prior authorization is not possible, will still require submission of appropriate documentation with the claim for review for payment.

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Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Criteria:

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by TennCare[SM]) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Unerupted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy or intellectual disability) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

The use of sedation and/or nitrous oxide inhalation is not considered medically necessary when administered for the convenience of the provider.

The use of anxiolysis → non-intravenous conscious sedation →intravenous (conscious sedation) → moderate sedation should be a linear incremental progression decision and thought process, always beginning with the least possible sedative impact on the child that will allow successful treatment.

Sedation and or nitrous oxide may be deemed medically necessary service when a patient's cognitive abilities level of anxiety, or behavior prevent routine delivery of dental care and communicative guidance proves insufficient.

The goal of sedation is to:

- protect the patient's safety and welfare,
- minimize physical discomfort and pain;
- control anxiety,
- control behavior and/or movement to allow safe completion of the procedure(s)

The provider must return the patient to a state in which safe discharge from medical supervision is assured; (as determined by recognized criteria if possible.)

The objective of minimal and moderation sedation is to assure the patient is in a receptive state to enhance communication, cooperation, and attain optimal outcome of all procedure(s).

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The patient's chart must contain and document at a MINIMUM:
For each visit or appointment that sedation is employed

- **The patient's presenting behavior or condition that requires sedation be employed**
- Documentation that informed consent was obtained for all forms of sedation including nitrous oxide
- The time sedation began,
- Monitoring of patient's vital signs during sedation,
- The time the sedation was discontinued, and
- For inhalation sedation/nitrous oxide:
  - Documentation that the patient received 100 percent oxygen for a minimum of 3-5 minutes, after cessation of nitrous oxide administration.
  - The provider must assure patient has completely recovered to the same cognitive or responsive state that existed prior to sedation.
  - L/min N2O and L/min O2 utilized at time patient was clinically sedated

15.10 Criteria for Restraint of Pediatric and Special Needs Patients

Participating providers must comply with the following rules of the Tennessee Board of Dentistry, 0460-01-.18. Failure to comply may result in penalties up to, but not limited to, termination from participation as a provider with the TennCare program:

- **Purpose –** The purpose of this rule is to recognize the unfortunate fact that pediatric and special needs patients may need to be restrained in order to prevent injury and to protect the health and safety of the patients, the dentist, and the dental staff. To achieve this, it will be important to build a trusting relationship between the dentist, the dental staff and the patient. This will necessitate that the dentist establishes communication with the patient and promote a positive attitude towards oral and dental health in order to alleviate fear and anxiety and to deliver quality dental care. Providers should always strongly consider a more minimally invasive treatment, ex SDF.
- **Training Requirement –** Prior to administering restraint, the dentist must have received formal training at a dental school or during an American Dental Association accredited residency program in the methods of restraint described in paragraph (4) of this rule.
- **Pre-Restraint Requirements**
  - Prior to administering restraint, the dentist shall consider:
    - The need to diagnose and treat the patient;
    - The safety of the patient, dentist, and staff;
    - The failure of other alternate behavioral methods;
    - The effect on the quality of dental care;
    - The patient's emotional development; and

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  - The patient's physical condition.
- Prior to administering restraint, the dentist shall obtain written informed consent from the parent or legal guardian and document such consent in the dental record

- **Method of Restraint**

  The **Physical Restraint or Medical Immobilization Method**

  This method may be used to partially or completely immobilize the patient for required diagnosis and/or treatment if the patient cannot cooperate due to lack of maturity, mental or physical disability, failure to cooperate after other behavior managements techniques have failed and/or when the safety of the patient, dentist, or dental staff would be at risk without using protective restraint. This method should only be used to reduce or eliminate untoward movement, protect the patient and staff from injury, and to assist in the delivery of quality dental treatment. If restraint or immobilization is deemed necessary, the least restrictive technique shall be used.

Use of this method shall not be used:

- With cooperative patients;
- On patients who, due to their medical or systemic condition, cannot be immobilized safely;
- As punishment; or,
- Solely for the convenience of the dentist and/or dental staff
- Dental Hygienist and dental assistants shall not use the methods described in paragraph 4 by themselves but may assist the dentist as necessary.
- The patient's record shall include:
  - Written informed consent from parents or legal guardians;
  - Type of method used;
  - Reason for use of that method;
  - Duration of method used; and,
  - If restraint or immobilization is used, type of restraint or immobilization used
- Parents or legal guardians must be informed in advance of what treatment the patient will receive and why the use of restraints may be required. Parents or legal guardians shall be informed of the office policy concerning parental presence, the benefits and risks of parental presence, and of their opportunity to choose a different practitioner for the child if they are not comfortable with the office policy.
- Patents or legal guardians may not be denied access to the patient during treatment in the dental office unless the health and safety of the patient, parent or guardian, or dental staff would be at risk. The parent or guardian shall be informed of the reason they are denied access to the patient and both the incident of the denial and the reason for the denial shall be documented in the patient's dental record.

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Authority: *T.C.A. §§4-5-202, 4-5-204, 63-5-105, and 63-5-108.*

15.11 Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

- Diagnostic radiographs – periapicals or bitewings preferred.
- Copy of detailed treatment plan
- Intra-oral photographs clearly identifying the condition in cases of gingival hyperplasia

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Periodontal scaling and root planing per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may
require local anesthetic."
Criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
    - Radiographic evidence of root surface calculus.
    - Radiographic evidence of significant loss of bone support

Periodontal gingival flap surgical procedures must meet the following criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites after

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scaling and root planing

- Moderate to severe bone loss.

Gingivectomy procedures must meet the following criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites of 5mm or greater after periodontal scaling and root planing

Narrative of hyperplasia or hypertrophy associated with drug therapy, orthodontic treatment, hormonal disturbances, or congenital defects.
Or, evidence of juvenile periodontitis.

15.12 Criteria for Minor Treatment to Control Harmful Habits

Removable appliance therapy (D8210) and fixed appliance therapy (D8220) treatments are covered services to control harmful habits. These treatment services include appliances for thumb sucking and tongue thrusting. Removable indicates patient can remove appliance. Fixed indicates patient cannot remove appliance.

Procedure codes D8220 or D8210 require prior authorization and must be submitted with the following documentation:

- A duplicate set of pre-treatment study models or a duplicate set of diagnostic pre-treatment digital photographs that clearly demonstrate that there is existing damage to the permanent arch alignment being created by the thumb habit or tongue thrust. Radiographs, photographs, or study models

  will not be returned.
- A panoramic radiograph, if available.
- A letter from a speech pathologist documenting the thumb habit or tongue thrust is causing speech pathology, if available or,
- A letter from the primary care physician indicating the thumb habit or tongue thrust is causing a nutritional problem, if available.

The allowable fee includes records, adjustment appointments and any appliance repairs or replacements. The procedure can only be performed once in a lifetime.

15.13 Orthodontic Treatment Criteria

Orthodontic services are covered for Enrollees under 21. Orthodontic treatment for cosmetic purposes is not a covered benefit. If DentaQuest does not score the Member's malocclusion severity assessment (MSA) at 28 or above, DentaQuest will determine whether orthodontic services are medically necessary to treat one of the medical conditions contained in the definition of handicapping malocclusion. If DentaQuest has determined that malocclusion scores 28 or above on the DentaQuest approved MSA, orthodontic services are covered. The following outlines the policies and procedures associated with Orthodontics covered under the TennCare dental program:

1. Members must be referred to a participating orthodontist by a General or Pediatric Dentist.
2. DentaQuest will refer Members to licensed orthodontists or pediatric dentists with a

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certificate indicating that they are board eligible or board certified in orthodontics.

3. Providers should contact DentaQuest on each date of service to verify eligibility. Orthodontic services will only be reimbursed if rendered on a date when the Member is eligible.
4. Orthodontic cases must be submitted to DentaQuest for approval through one of the following means:
    a. Submission of a duplicate set of diagnostic quality photographs (photographs will not be returned) to include:
        i. Facial photographs (right and left profiles in addition to a straight on facial view)
        ii. Frontal view, in occlusion, straight on view
        iii. Frontal view, in occlusion, from a low angle
        iv. Right buccal view, in occlusion
        v. Left buccal view, in occlusion
        vi. Maxillary occlusal view
        vii. Mandibular occlusal view
    b. Submission of the alginate to OrthoCAD. OrthoCAD will enable dental Providers to send electronic models to DentaQuest electronically. OrthoCAD offers a low-cost alternative to submitting plaster models. The threat of broken, lost or otherwise compromised models is eliminated. All you need is a computer and Internet access.
    c. In lieu of the above photographic requirement, DentaQuest will accept a duplicate set of diagnostic quality photographs of study models (photographs will not be returned) with the following parameters:
        i. Occlusal view of the maxillary arch
        ii. Occlusal view of the mandibular arch
        iii. Right buccal view, in occlusion
        iv. Left buccal view, in occlusion
        v. Facial view, straight on and low angle, in occlusion
        vi. Posterior view of models in occlusion
    d. DentaQuest will accept a duplicate case of the study models. Study models will not be returned.
5. A completed TennCare Orthodontic Readiness Necessity Form must be submitted to DentaQuest by the orthodontist or Pediatric dentist who is seeking authorization. (see Appendix A of this manual for required form).
6. Evidence in the form of a letter from a Speech Pathologist or Licensed Physician to support evidence of Handicapping Malocclusion for inability to eat, speak, chew, or prove nutritional deficiency.

Authorization

Duplicate photographs and all other applicable documentation sent to DentaQuest by the Provider via regular mail or OrthoCAD will **not** be returned to the dentist.

DentaQuest's orthodontic consultants utilize the photographs, OrthoCAD, radiographs and any applicable narrative to determine the medical necessity of the case.

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Only eligible TennCare Members will be considered for orthodontic treatment.

Denials
If the case is denied, pre-determination EOB will be sent to the Provider notifying them of the denied case within 24 hours of the denial determination. The Member will also receive written notification of the denial.

For denied cases, the models, radiographs, and any other accompanying materials will not be returned to the Provider. DentaQuest is required to keep the records in order to meet state required turnaround time for potential Member appeals.

If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. In order to receive payment of records for cases that are denied, a claim must be submitted on an ADA form including code D8660. The date of service will be the date the treatment plan, radiographs and/or photos, records and diagnostic models were performed by the provider.

Approvals
If the case is approved, the Provider will receive an approved predetermination form. The approved authorization will include authorization for one (1) comprehensive orthodontic treatment of the adolescent dentition (CDT code D8080) and up to twenty-three (23) periodic orthodontic treatments (CDT code D8670). Exceptions may be made for those cleft palate cases requiring orthognathic surgery.

A claim for D8680, Debanding and retention, will automatically be approved once the banding and 23 adjustments have been billed. Please do not submit the D8680 on the original authorization for comprehensive orthodontia.

Once the orthodontic appliance has been placed (banding), the Provider should submit for procedure code D8080 – Comprehensive Orthodontic Treatment of the Adolescent Dentition.

Ortho claims are recommended to be submitted through the Dental Office Toolkit or electronically through a clearinghouse.

As an eligible TennCare Member returns for periodic orthodontic treatments (CDT code D8670), the Provider must submit a claim for each visit.

Providers may bill up to one periodic orthodontic treatment per calendar month for the same eligible TennCare Member pursuant to rendering service.

23 months of adjustments are included in procedure code D8080 – Comprehensive Orthodontic Treatment with an approved authorization.

DentaQuest will pay authorized periodic orthodontic treatments (CDT code D8670) for a maximum count of twenty-three (23). Any periodic orthodontic treatments (CDT code D8670) beyond the number approved will not be billable and are included in the case rate. Exceptions may be made for those cleft palate cases requiring orthognathic surgery. Any periodic orthodontic treatments (CDT code D8670) authorized, but not performed will not be paid. Reimbursement is based on the Member's eligibility at the time of service.

Eligible TennCare Members shall not be charged for missed appointments.

If a Provider is unable to maintain a professional relationship with a TennCare Member, the Provider may terminate the relationship. Upon termination of the

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relationship by the Provider with the TennCare Member, such termination reason should be provided to the TennCare Member. Members that have been terminated by a Provider shall be referred back to DentaQuest by the Provider.

Eligible TennCare Members shall not be charged for broken brackets. Consideration for broken brackets is built into the orthodontic rate. It is understood, however, that excessive breakage that is deemed to be unacceptable to the Provider may prevent the Provider from maintaining a professional relationship with a Member.

D8680, debanding and retention, does not require a prior authorization. The criteria for payment of a claim for D8680 are clinical history of completed D8080 and completion of 23 adjustments (D8670). If member does not have these criteria present in clinical history (ex: were banded under commercial insurance) please attach a narrative to the claim describing the treatment and provider history.

Orthodontic Continuation of Care (New Patient)

DentaQuest requires the following information for possible payment of continuation of care cases:

- Completed Orthodontic Continuation of Care Form.
- Completed ADA claim form listing services to be rendered.
- A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.
- If the Member is private pay or transferring from a commercial insurance program, original diagnostic photographs (or OrthoCAD equivalent), radiographs (optional).
- Release for treatment from previous orthodontic provider.

If the Member started treatment under commercial insurance or private pay or another State Medicaid program, we must receive the ORIGINAL photographs of the diagnostic models (or OrthoCAD), or radiographs (optional), banding date, and a detailed payment history.

It is the Provider’s and Member's responsibility to get the required information. Cases cannot be setup for possible payment without complete information.

15.14 Criteria for Space Maintainers

Criteria for Unilateral Space Maintainer-Fixed

Space maintainers may be considered for payment if medically necessary for Members ages 2 through 12 based on the following criteria:

- If the primary cuspids, primary first molars or primary second molars are missing or needs to be extracted due to pathology.
- Limited to once per lifetime per quadrant.

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- Any stainless steel crown or orthodontic band that is part of the space maintainer is included in the space maintainer fee for the fixed space maintainer.
- Re-cementation for the first six months is included in the fee for the D1510 code. After six months, re-cementation is covered under the D1551/D1552/D1553 codes.
- Repair or replacement of the appliance is not reimbursed.
- Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost. Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing does not meet medical necessity for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the DentaQuest program. The same criteria are true in the lower arch as well.

If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss.

When there is a loss of a deciduous (primary) second molar and the position of the first permanent molar requires a distal shoe appliance, (D1575) to assure proper eruption, this code may be a covered benefit. Criteria that must be in the members chart to satisfy medical necessity include a diagnostic periapical image/x-ray of the edentulous space, and the unerupted first molar and appropriate narrative

Criteria for Fixed lingual Arch Space Maintainer-Fixed-Bilateral

Space maintainers may be considered for payment if medically necessary for Members ages 2 through 12 based on the following criteria:

- Is limited to once in a lifetime for each arch.
- Any associated stainless steel crown or orthodontic band that is part of the fixed space maintainer is included in the fee for the fixed space maintainer. A crown and a space maintainer cannot be submitted separately for payment if the space maintainer is attached to the crown.
- D1515 is a lingual arch space maintainer. It does not meet medical necessity requirement when only primary centrals or laterals are missing. Primary cuspids, primary first molars or primary second molars must be missing or need to be extracted due to pathology.

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- Repair or replacement of the appliance is not reimbursed.
- Re-cementation is included in the fee for the D1515 for six months after placement. Following six months, re-cementation is covered under D1550.
- Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost. Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing is not necessary for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the DentaQuest program. The same is true in the lower arch as well. If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss. Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss qualifies as medically necessary or a unilateral space maintainer qualifies as medically necessary when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

15.15 Criteria for Occlusal Guards

An occlusal guard (D9944, D9945, D9946) is a removable appliance designed to minimize the effect of bruxism and other occlusal factors. To determine medical necessity the following criteria must be met:

- Occlusal guards require prior authorization.
- Occlusal guards do not meet medical necessary guidelines for patients with primary teeth.
- A narrative must be included on or with the claim defining why the occlusal guard is medically necessary. There must be clinical evidence and documentation (either a model or intraoral photograph if requested by DentaQuest) of unusual and significant wear and damage to the patient's dentition. Occlusal guards or and device or appliance for the purpose of tooth whitening trays or athletic mouth guards are not consideredmedically necessary criteria.
- The fee for the occlusal guard includes six months of follow up care, including adjustments.
-

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15.16 Criteria for Frenectomy (Frenulectomy or Frenotomy)

Maxillary Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Should not be rendered until the permanent incisors and cuspids have erupted and the diastema has had an opportunity to close naturally
- Digital photographs must be provided

Mandibular Labial Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Digital photographs must be provided

Mandibular Lingual Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Any available documentation from speech pathologists, pediatricians, oral surgeons, otolaryngologists, or lactation specialists should be provided

Criteria:

Maxillary frenectomy: Treatment should not be rendered until the permanent incisors and cuspids have fully erupted and any diastema has had an opportunity to close naturally. If orthodontic therapy is indicated, the frenectomy should be performed only after the diastema is closed as much as possible to achieve stable results.

Mandibular labial frenectomy: Treatment should be considered if the position of the mandibular labial frenum is causing inflammation, recession, pocket formation, and possible loss of the alveolar bone and/or tooth.

Mandibular lingual frenectomy: Treatment should be considered if the position of the lingual frenum is considered to be a contributing factor in malocclusion. A complete orthodontic evaluation, diagnosis and treatment plan are necessary prior to performing a frenectomy in this area. If it is suspected that the position of the lingual frenum is a contributing factor in altered speech patterns, a letter from a speech pathologist, pediatrician, oral surgeon, otolaryngologist and/or a

lactation specialist must be included with the claim.

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15.17 Criteria for Use of Silver Diamine Fluoride (caries arresting medicament application)

DentaQuest, as a market leader in improving oral health, strongly supports the use of appropriate medically necessary diagnostic and preventive services. Consistent with that fundamental strategy, ADA CDT Code D1354 (Interim caries arresting medicament application) is now a covered service. The medicament MUST be a product approved by FDA for use as a caries arresting medicament, and use must be consistent with the narrative in the descriptor of this code.

DentaQuest and TennCare™ advocate that the clinical indication for the use of Silver Diamine Fluoride is the management and arresting of *significant areas* and frequency or numbers of carious lesions.

SDF has been recommended for patients of any age with:

- Extreme caries risk
- Behavioral or medical management challenges
- Numerous carious lesions that are not treatable in one operative visit
- Difficult to treat lesions
- No access to comprehensive care

Administration of this benefit will be limited to four applications per tooth (limit 6 teeth per date of service) during enrollee's total period of eligibility, and there is a four-week period after application that restorative treatment is not a covered service on the same tooth that received SDF. This will assure the Silver Diamine Fluoride treatment and effect on the carious tooth structure has been able to approach desired completion. After a four-week interim period for completion of reaction, restorative treatment for carious teeththat received SDF., (based on medical necessity) will then be covered service(s).

DentaQuest and TennCare have lifted the restriction of provider use of SDF and other Fluoride treatments (D1206, D1208) on the same date of service. Change in policy is based on current science-based evidence, supported by research with the collaboration and oversight of trusted scientific organizations.

The primary safety concern of combining fluoride varnish and silver diamine fluoride would be for fluoride intake. A full drop of SDF, which is typically enough to treat all the carious lesions in a child's mouth, has about 1/7th the fluoride of a varnish packet (see the math below). So, the added fluoride from SDF is marginal to the varnish.

In cases where loss of a sealant is a concern due to patient functional or dietary oral habit as well as faulty placement, an application of SDF (D1354) to a non-cavitated occ surface prior to placement of sealant (D1351) should lower risk of unprotected tooth surface experiencing carious activity. Sealant placement should be performed on a subsequent visit to SDF application.

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16.0 General Definitions

The following definitions apply to this Office Reference Manual:

Adverse Action – Adverse action affecting TennCare services or benefits as it relates to actions under the *Grier Revised Consent Decree* shall mean, but it is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits, as well as any other act or omission of the TennCare Program which impairs the quality, timeliness, or availability of such benefits. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Agreement – The Provider Agreement between DentaQuest and Provider, including all attachments thereto.

Appeal Process – The process whereby an Enrollee exercises their right to contest verbally or in writing any adverse action taken by DentaQuest to deny, reduce, terminate, delay or suspend a Covered Service as well as any other acts or omissions of DentaQuest which impair the quality, timeliness, or availability of such benefits. The appeal process shall be governed by TennCare rules, regulations and any and all applicable court orders and consent decrees. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Benefits – Shall mean the health care package of services developed by the Division of TennCare and which define the covered services available to TennCare enrollees. The Agreement focuses on Dental benefits although Benefits provided by the Enrollee's MCO are sometimes mentioned. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

CAQH – Shall mean "The Council for Affordable Quality Healthcare," a nonprofit alliance of health plans and trade associations, working to simplify the first steps of the provider credentialing and application data collection process.

Clean Claim – A claim received by DentaQuest for adjudication that requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by TennCare.

Complaint– A Member's right to contest an action taken by the Contractor or service provider that does not meet the definition of an adverse action.

Contract or TennCare Dental Benefits Manager Contract - Shall mean the contract between TennCare and DentaQuest, identified as Edison Contract ID #36736, wherein DentaQuest contracted to be responsible for the financial, clinical and managerial aspects of the TennCare dental benefits management (DBM) program.

Covered Service – Shall mean dental services, benefit services and benefits that are Medically Necessary, including EPSDT services, and that satisfy all the criteria set forth in the TennCare Program rules, policies, the Agreement, and in this Provider Office Reference Manual. ***See also TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

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Dental Benefits Manger (DBM) – Dental Benefits Manager shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent such services are covered by TennCare. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13- 14-.01***

Dental Home – A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible and coordinated way.

DentaQuest - Shall refer to DentaQuest USA Insurance CO., LLC.

DentaQuest Service Area - Shall be defined as the State of Tennessee.

Disallowed – Procedures that are not paid benefits by TennCare or collectable from the TennCare Member.

Division of TennCare^{SM} - Shall mean the Tennessee Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare responsible for administering the TennCare^{SM} Program.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – In Tennessee this program is also referred to by its program name, **TennCare Kids**. EPSDT is a covered benefit for Medicaid-enrolled children only, and shall mean:

- Screening in accordance with professional standards, inter-periodic diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid enrollees under age twenty-one (21); and
- Health care, treatment and other measures described in 42 U.S.C. § 1396a (a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01

Emergency Medical Condition – Emergency Medical Condition, including emergency mental health and substance abuse emergency treatment services, shall mean the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

- Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For Medicaid enrollees only, copayments are not required for emergency services. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Emergency Services – Covered inpatient and outpatient Emergency Medical Condition services that are furnished by a Provider who is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee – Enrollee shall mean an individual eligible for and enrolled in the TennCare

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Program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act.

Handicapping Malocclusion - For the purposes of determining eligibility under these regulations shall mean the presence of abnormal dental development that has at least one of the following:

- A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
- The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.
- Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These conditions may be caused by other medical conditions in addition to the misalignment of the teeth.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Mandates the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of individually identifiable health care information.

Health Information Technology for Economic and Clinical Health (HITECH) Act – Enacted to improve health care quality, safety and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information; to adopt an initial set of standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology; and to establish the capabilities and related standards that certified electronic health record technology (Certified HER Technology) shall need to include in order to, at a minimum, support the achievement of the proposed meaningful use by eligible professionals and eligible hospitals.

Managed Care Organization (MCO) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Medically Necessary is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71-5- 144, applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in the TennCare rules, consistent with the statutory

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provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Medical Necessity Determination – A decision made by the Chief Medical Officer of the Division of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of Medical Necessity contained in Tennessee Code Annotated, Section 71-5-144 and these rules as defined herein.

Items or services that are not determined medically necessary shall not be paid for by TennCare. ***See TennCare Rule 1200-13-13-.01, TennCare Rule 1200- 13-14-.01 and See TennCare Rule 1200-13-16(32)***

Medical Necessity Guidelines/Clinical Criteria – Evidence-based guidelines approved by the Chief Medical Officer of the Division of TennCare for the purpose of guiding Medical Necessity determinations

Member - Shall mean a TennCare[SM] Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Member Grievance - Shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does not meet the definition of Adverse Action.

National Provider Identifier (NPI) – The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for Covered Health Care Providers. Covered Health Care Providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI must be used in lieu of Legacy Provider identifiers in the HIPAA standards transactions.

Non-covered Benefit/Services – Items and services that are not within the scope of defined benefits for which a beneficiary is eligible under TennCare, including cost-effective alternative services and medical items and services that are in excess of any applicable limits on such items or services that might otherwise be covered. With the exception of cost-effective alternative services, non-covered services under TennCare, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as “medically necessary”, regardless of the medical circumstances involved.

Non-participating Provider – Shall mean a DentaQuest dental provider who is not contracted as a DentaQuest Network Provider under the TennCare Program. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Provider or Participating Provider - Shall mean a TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Dental Benefits Manager.

Protected Health Information (PHI) – Individually identifiable health information held or maintained by a covered entity or its business associates that is transmitted or maintained in any form or medium. This includes identifiable demographic and other

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information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.

For purposes of the Privacy Rule, genetic information is considered to be health information.

Provider/DentaQuest Office Reference Manual (ORM) – The manual provided that clearly defines TennCare Program covered services, limitations, exclusions and utilization management procedures, including, but not limited to, prior approval requirements and special documentation requirements (hospital readiness form, orthodontic readiness form, documentation of nutritional problems [general pediatric records including growth data], speech/hearing evaluations [may include school records]) for treatment of enrollees. The terms of the Provider Office Reference Manual are incorporated by reference into the DentaQuest Provider agreement. In the event of a discrepancy between the ORM and the TennCare Rules, the TennCare Rules shall apply.

Specialty Services – Includes Endodontic, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, and Prosthodontics.

State – State of Tennessee

TennCare– The program administrated by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.

See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01

Unsecured PHI – Protected health information that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

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17.0 Confidentiality and Safeguards

Provider acknowledges it is a covered entity under the HIPAA Rules and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") Rules. In accordance with HIPAA/HITECH, Provider shall comply with requirements of HIPAA/HITECH including, but not limited to, the Transactions and Code Sets, Security, Breach Notification, and Privacy Rules.

A. **Transactions and Code Sets:** Provider shall comply with the requirements of 45

C.F.R. Part 162, the HIPAA Transactions Rule. Compliance includes conducting electronic transactions using all applicable data content and data conditions of adopted standards and, when required, using the applicable formats for adopted standards. Providers must require any entity that conducts such transactions on its behalf to comply with all applicable requirements of 45 C.F.R. Part 162 and to require any Subcontractor to comply with all applicable requirements of 45 C.F.R. Part 162.

B. **Security:** Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart

C. the HIPAA Security Rule. Under the Security Rule, health care providers (and

other covered entities) must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information and implement safeguards sufficient to reduce the identified risks and vulnerabilities to a reasonable and appropriate level.

D. **Breach Notification:** Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart D, the HIPAA Breach Notification Rule. When required by the Breach Notification Rule, Provider shall notify applicable parties of a "breach" of unencrypted protected health information. In addition, Providers shall also notify DentaQuest immediately upon becoming aware of any provisional or actual breach as it relates solely to TennCare members.

E. **Privacy:** Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart E, the HIPAA Privacy Rule. Among other things, the Privacy Rule requires a Provider to:

- Implement reasonable and appropriate safeguards to ensure that it uses and discloses Protected Health Information only for treatment, payment, health care operations, and other purposes permitted or required by the Privacy Rule.
- Establish appropriate mechanisms to limit the use or disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use or disclosure.
- Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties upon hire and at appropriate intervals thereafter and maintain appropriate documentation of such training.
- Engage its business associates in business associate agreements that meet the requirements of the Privacy and Security Rules.

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- Make Protected Health Information available in accordance with 45 C.F.R. § 164.524; amend Protected Health Information and incorporate any amendments as required by 45 C.F.R. § 164.526; and account for disclosures of patients' Protected Health Information as required by 45 C.F.R.

  § 164.528.

- Provide patients with a notice of privacy practices in the manner and with the content required by the Privacy Rule, including information that informs patients of their privacy rights.

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18.0 Sensitive Information

Provider must comply with the following requirements with respect to certain sensitive information:

A. Alcohol and Drug Abuse Treatment Records: When Provider receives information subject to the Federal Substance Abuse Rule (42 C.F.R. Part 2), Provider must comply with 42 C.F.R. Part 2, which generally prohibits re-disclosure without written consent. Note that a general written consent (including a HIPAA-compliant authorization) is *not* sufficient. In most cases, the following statement will accompany these records and must be included with such records when Provider discloses them to another party:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B. Federal Tax Information (FTI): Any FTI made available to Provider must be used only for the purpose of carrying out the provisions of this Agreement. Federal Tax Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of the Provider is strictly prohibited.

Failure to comply with federal regulations regarding SSA, Medicaid, CHIP, and Substance Abuse, FTI, and PHI data may result in criminal and civil fines and penalties.

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APPENDIX A – ADDITIONAL RESOURCES

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at www.DentaQuestgov.com. Once you have entered the website, click on 'Tennessee' and then go to "Provider Resource Documents" to access the following resources:

TennCare Specific Forms:

- Malocclusion Severity Assessment Form
- Orthodontic Continuation of Care Form
- Orthodontic Readiness Form
- Outpatient Hospital Readiness Form
- Provider Appeal Form
- Dental Member Appeal Form
- Member Unfair Treatment Complaint Forms
- Member Agreement to Pay Non-Covered Treatment

DentaQuest General Forms:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- OrthoCAD Submission Form
-

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 855.418.1623.

You may also find copies of these forms within this manual.

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Malocclusion Severity Assessment Form

Patient Name: ________________________________

ID#__________________________Provider Name____________________________________

INTRA-ARCH DEVIATION

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post					Total Score		X1	

Ant = Anterior teeth (4 incisors); Post = Posterior teeth = (Include canine, premolars and first molar). No. = number of teeth affected

INTER-ARCH DEVIATION

Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Open bite	No.	P.V.	Score
						X2	
						Total Score	

*Score maxillary or mandibular incisors. No. = number of teeth affected; P.V. = point value 2.

Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
Canine	Distal		Mesial		Crossbite		Open bite				
	Right	Left	Right	Left	Right	Left	Right	Left			
1st Premolar											
2nd Premolar											
1st Molar											

No. = number; P.V. = point value;

Total Score	
Grand Total	

Orthodontics

Malocclusion Severity Assessment Summary of Instructions

Score: 2 points for each maxillary anterior tooth affected. 1 point for each mandibular incisor and all posterior teeth affected.

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1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
    a. Open spacing. One or both interproximal tooth surfaces and adjacent papilla are visible in an anterior tooth; both interproximal surfaces and papilla are visible in a posterior tooth.
    b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially eruption.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the “Malocclusion Severity Assessment Record”

Introduction

This record (not an examination) is intended to assess the severity of the malocclusion according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health and function. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the “Malocclusion Severity Assessment Record.” The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
    a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
    b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

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c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.

d. Spacing

i. Open spacing refers to tooth separation that exposes to view the interdental papilla on the alveolar crest. Score the number of papilla visible (not teeth).

ii. Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.

a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing

b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.

d. Spacing

i. Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papilla of a tooth. Score the number of teeth affected (not the spaces).

ii. Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

Inter-Arch Deviations

When casts are assessed for inter-arch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.

a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.

b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.

c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

d. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the

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mandibular incisors when the posterior teeth are in terminal occlusion Edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.
   a. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion

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Orthodontic Continuation of Care Submission Form

Date: ________________

Patient Information		
Name (First & Last):	Date of Birth:	SS or ID#:
Address:	City, State, Zip:	Area Code & Phone number:
Group Name:	Plan Type:	
Provider Information		
Dentist Name:	Provider NPI #:	Location ID #:
Address:	City, State, Zip:	Area Code & Phone number:

Name of Previous Vendor that issued original approval:_____________________________________

Banding Date:______________Case Rate Approved by Previous Vendor: _________________________

Amount paid for dates of service that occurred prior to DentaQuest: _______________________________

Amount owed for dates of service that occurred prior to DentaQuest: _______________________________

Balance expected for future dates of service: ____

Numbers of adjustments remaining: ____

Additional information required:

- If the member is transferring from an existing Medicaid program: A copy of the original orthodontic approval.
- If the member is private pay or transferring from a commercial insurance program: Original diagnostic photos or OrthoCad equivalent, radiographs (optional).

Submit to:
DentaQuest - TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.834.3452

If approved through a prior Medicaid vendor, please submit the following:

- A complete Orthodontic Continuation of care form
- A completed 2006 or greater ADA claim form listing the services to be rendered
- A copy of the member's prior approval letter including the total approved case fee an payment structure
- Detailed payment history

If approved through a private arrangement or commercial plan also include:

- A copy of the original study models or a complete set of diagnostic photographs prior to the patient being banded
- Panorex Radiograph

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TennCare Dental Orthodontic Readiness Necessity Form

This form is required to be submitted with documentation as outlined (Orthodontic Treatment Criteria) of the TennCare Provider Office Reference Manual to determine if the patient qualifies for orthodontic treatment in the TennCare program. Failure to complete this form in its entirety may result in a denied request.

As a condition for coverage, orthodontic treatment must be proved medically necessary. Medical Necessity can be established upon:

The substantiated presence of one of the three medical conditions listed below or a DentaQuest-scored Malocclusion Severity Assessment (MSA) result of 28 or higher. (Important note: An MSA score is never used to deny orthodontic treatment.)

Patient Information		
Name (First & Last):	Date of Birth:	SS or ID#:
Address:	City, State, Zip:	Area Code & Phone Number:
Referring DDS or Pediatric Dentist:	Address:	City and State:

Tissue laceration from a deep impinging overbite.

__YES, Along with this form, please submit intraoral photographs or study casts, which document the laceration.

_NO

A **nutritional deficiency** has been diagnosed by a licensed physician, and the substantiated nutritional deficiency cannot be corrected without orthodontic treatment.

__YES, Along with this form, please submit supporting documentation from the physician who diagnosed or attempted to treat patient's nutritional deficiency.

__NO

_ DON'T KNOW

Speech pathology has been diagnosed by a licensed and certified Provider, and the substantiated speech pathology cannot be corrected without orthodontic treatment.

_ YES, Along with this form, please submit supporting documentation from the patient's speech pathologist.

__NO

_ DON'T KNOW

I certify, by my signature, that all responses on this form are true and I agree with the following statements:

I have consulted with the referring general dentist or pediatric dentist and the patient has completed all restorative treatment necessary to begin orthodontic treatment.

I have personally examined the patient and the patient's oral hygiene and periodontal condition are within acceptable limits for orthodontic treatment.

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I agree to submit my complete orthodontic record and treatment notes on the patient within 3 days of a request made by DentaQuest or TennCare, if denials of authorization by DentaQuest results in an appeal or anytime such records are requested by DentaQuest or TennCare.

Orthodontist'ssignature____

Orthodontist's name____

Street Address____

City_______________________**State**__________**Date**____________

Submit to: DentaQuest-TennCare, Ortho Readiness PO Box 2906 Milwaukee, WI 53201-2906 or FAX: 262.241.7150 or 888.313.2883

Any modification of this form will not be accepted.

This form may be downloaded from the DentaQuest website: www.dentaquest.com

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TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form

This form is required to be submitted with documentation as outlined in Section 15.00, Criteria for Provision of Dental Treatment in an Inpatient/Outpatient Hospital ("Hospital") Facility or in an Ambulatory Surgical Center (ASC)

Patient Name ______________________________

Patient ID ______________________________

Patient Address ______________________________

____

Date ______________________________

A. I certify that I have examined this patient

☐ Yes ☐ No Date of Exam __________

B. There is pathology or injury requiring extensive dental treatment (restorative or surgical)

☐ Yes ☐ No

C. I certify that I have attempted to treat this patient in my office

☐ Yes ☐ No Date __________

D. If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)

☐ Yes ☐ No

If no, why was a referral not made?

____

____

E. I have attempted to manage the member with Silver Diamine Fluoride in the office (general and pediatric dentists)

☐ Yes ☐ No

F. I have offered Silver Diamine Fluoride treatment to the member in the office as an alternative to treatment under general anesthesia in a medical facility (general and pediatric dentists)

☐ Yes ☐ No

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G. If answer to “E” or “F” is no, please explain why SDF has not been used (general and pediatric dentists

____
____
____

H. Were radiographs taken to determine diagnosis?

☐ Yes ☐ No

I. I have submitted all the documentation required for prior authorization as described in the TennCare Office Reference Manual

☐ Yes ☐ No

J. If answer to “H” or “I” is no, please explain why the documentation is not being submitted:

____
____

DentaQuest reserves the right to request a second opinion for any inpatient/ outpatient hospital or ambulatory surgery center request.

I Certify That the Above Information Is Correct

Name of Provider ________________________
Provider Signature ________________________
Date ________________________

Submit to:
DentaQuest – TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
FAX: 262.241.7150 or 888.313.2883

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TennCare Dental Provider Appeal Form (Post-Service Appeals)

Member Name:____

Member ID Number:____

Date of Service:____

Date EOB received:____

Authorization number:_______________________________________

Date authorization was received:_______________________________

Provider Name:____

Location Number:____

Office Contact:____

Reason for Appeal:____

____

____

____

____

Outcome office is requesting: ____

____

____

____

Submit to:
DentaQuest – TennCare
Attn: Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.834.3452

DentaQuest LLC January 1, 2022
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TennCare Dental Member Appeal Form (Pre-Service Appeals)

Dental Appeal Form

Use this page only to file a TennCare Dental Appeal.

Fill out **both pages**. These are facts **we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may not get a fair hearing. Need help understanding what facts we need? Call us for free at **1-855-418-1622**. If you call, we can also take your **appeal by phone**.

1. Who is the person that wants to appeal?

Full Name ____

Date of Birth_____/_____/_________ Social Security Number________-____-________

Or number on their TennCare card____________________

Current Mailing Address____________________________

City____ State_____________Zip Code____________

The name of the person we should call if we have questions about this appeal:

______________________A daytime phone number for that person (_____)________________________-

____

2. Who filled out this form?

If not the person who wants to appeal, tell us your name:__________________________________

Are you a: Parent, relative, or friend Advocate or attorney _ Dentist or health care provider

3. What is the appeal for?

(Place an X in the box beside the best answer below)

☐ Need care or medicine. (Fill out Part A on page 2.)

☐ Have bills or paid for care or medicine you think TennCare should pay. (Fill out Part B on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency, you may be able to get an expedited appeal. This means your appeal will be decided in 3 business days. An emergency means that if you don't get a decision on your appeal within 3 business days, it could **seriously jeopardize (put in danger):**

- Your life;
- Your physical health;
- Your mental health; or
- Your ability to reach, get back, or keep your mind and body as healthy as possible.

Do you still think you have an emergency? If so, you can ask TennCare for an expedited appeal. DentaQuest will decide if your appeal should be expedited because you have an emergency. If so, then your appeal will be decided in 3 business days from the date TennCare receives your appeal. But, if DentaQuest decides that your appeal should **not** be expedited, then you will get a hearing within 90 days. **(Keep reading.** There is **1 more page** for you to fill out**.)**

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Also, if your doctor thinks you need an expedited appeal, your doctor can go to **tn.gov/tenncare**. Click "Providers," and then click "Miscellaneous Provider Forms" to fill out a "Provider's Expedited Appeal Certificate." Your doctor should fax the certificate to **1-866-211-7228.** DentaQuest will review the certificate and make a decision about your appeal. If DentaQuest thinks the appeal should be expedited, you will get a decision on your appeal in 3 business days from them. But, if DentaQuest decides your appeal should **not** be expedited, then you will get a hearing within
date you filed your appeal.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send your problem.

____

____

____

____

To see which Part(s) you should fill out below; look at number 3 on page 1.

Part A. Need care or medicine. What kind - be specific:______________________________

What's the problem?

_ Can't get the care or medicine at all _The care or medicine is being cut or stopped

_ Can't get as much of the care or medicine that I need Waiting too long to get the care or medicine

Did your doctor prescribe the care or medicine?___Yes___No If yes, doctor's name________________

Have you asked your health plan for this care or medicine? Yes No If yes, when? _

What did they say?____________________________________

Did you get a letter about this problem?___Yes__No If yes, the date of the letter:_______________

Who was the letter from? _______________________

Are you getting this care or medicine from TennCare now? Yes No

Do you want to see if you can keep getting it during your appeal? Yes No

Does your doctor say you still need it?___Yes__No If yes, doctor's name:_________________________

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part B. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine__________

Name of doctor, drugstore, or other place that gave you the care or medicine __________________

Their phone number (____ _____) Their address__

Did **you pay for the care or medicine and want to be paid back?** __Yes No
If yes, you must send a copy of a receipt that proves you paid for the care or medicine.

If you didn't pay, are you getting a bill? __Yes No

If yes, and you think TennCare should pay, you must send a copy of a bill. Tell us the date you first got the bill (if you know):____

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How to file your dental appeal:

Make a copy of the completed pages to keep. **Then, mail these pages and other facts to:**
TennCare Member Medical Appeals
PO Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll free) to **1-888-345-5575**
Keep a copy of the page that shows your fax went through.

To appeal by **phone**, call **1-800-878-3192** for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair Treatment in TennCare.
No one is treated in a different way because of race, color, birthplace, language, sex, religion, age, or disability.
If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**

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State of Tennessee
Division of TennCare
TennCare Member
Medical Appeals PO Box
000593
Nashville, Tennessee 37202-0593

Appeal Authorization Form

Patient's Printed Name________________________________

Patient's Date of Birth________________________________

Doctor's Printed Name________________________________

Yes, I would like to request a Fair Hearing from TennCare for

____

(Drug, item, or service)

☐ I give my doctor permission to file a fair hearing request on my behalf.

☐ I want to keep getting the services I've been getting until my appeal is over. I understand that my health plan will look at my case and decide if I can keep getting this care during my appeal.

____________________ ____________________
Signature of Patient **Date**

____
Address

____
Phone Number

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TennCare Discrimination Complaint

Federal and State laws do not allow the TennCare Program to treat you differently because of your **race, color, birthplace, disability, age, sex, religion, or any other group protected by law.** Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1. * Write your name and address.

Name:

____

Address:____

____Zip__________________
Telephone: Home: ( )_______________Work or Cell: ( )
Email Address:___________________________

Name of MCO/Health Plan:

____

2. * Are you reporting this complaint for someone else? Yes:________No:_________
If Yes, who do you think was treated differently because of their **race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?**

Name:

____

Address:

____

____Zip__________

Telephone: Home: (_____)__________________Work or Cell:
(_____)________________

How are you connected to this person (wife, brother, friend)?

____

Name of this person's MCO/Health Plan:

____

3. * Which part of the TennCare Program do you think treated you in a different way:

Medical Services Dental Services Pharmacy Services______

Long-Term Services & Supports______ Eligibility Services______ Appeals_______

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4. * How do you think you were you treated in a different way? Was it your

Race____ Birthplace_____ Color_____ Sex_____ Age_____

Disability______ Religion____Other_________________________________

5. What is the best time to talk to you about this complaint?

____

6. * When did this happen to you? Do you know the date?
Date it started:__________________Date of the last time it happened:__________________

7. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

____

____

____

8. * What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

____

____

____

9. Did anyone see you being treated differently? If so, please tell us their:

Name Address Telephone

____

____

____

10. Do you have more information you want to tell us about?

____

____

____

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11. * **We cannot take a complaint that is not signed**. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

____

(Sign your name here if you are the person this complaint is for) (Date)

____

(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her. Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

____

(Sign here if you are reporting this for someone else) (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:

____

(Sign here if you are either a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail or email the completed, signed Complaint **and** the signed

Agreement to Release Information pages to us at:
TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

You can also call us if you need help with this information.

TennCare Agreement to Release Information

To investigate your complaint, TennCare and your MCO/Health Plan may need to tell other persons or agencies important to this complaint your name or other information about you. **To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.**

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• I understand that during of the investigation of my complaint TennCare and

____________________________________(write name of your MCO/Health Plan on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.

• You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare or to your MCO/Health Plan without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature:____Date:________________
Name (Please print):_______
____ Address:____________
____ Telephone:___________

Need help? Want to report a complaint? Please contact or mail a completed, **signed** Complaint

and a signed Agreement to Release Information form:

TennCare OCRC
310 Great Circle Road, 3W
Nashville, TN 37243
Email: HCFA.fairtreatment@tn.gov

Phone: 1-615-507-6474 or for free at 1-855-857-1673
For free TRS dial/llamar al 711 and ask for 855-857-1673

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Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-855-418-1622 (TRS:711).

Kurdish: كوردی
ئاگاداری: ئەگەر بەزمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆرایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-855-418-1622 ..(TRS:711)بکە

Arabic: العربية
ملحوظة: اذا كنت تتكلم اللغة العربية فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-418-1622: (TRS: رقم هاتف الصم و البكم 711)

Chinese: 繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-418-1622 (TRS:711).**

Vietnamese: Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-418-1622 (TRS:711).

Korean: 한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-418-1622 (TRS:711).번으로 전화해 주십시오.

French: Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-418-1622 (TRS:711).

Amharic: አማርኛ
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ወደ ሚከተለው ቁጥር ይደውሉ **1-8855-418-1622** (መስማት ለተሳናቸው:**TRS:711).**

Gujarati: �જરાતી
�ચ ના: જો તમે �જ રાતી બોલતા હો, તો િન:�લ્ક ભાષા સહાય સેવાઓ તમારા માટ� ઉપલબ્ધ છ. ફોન કરો 1-855-418-1622 (TRS:711) .

Laotian: ພາສາລາວ
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.

German: Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-418-1622 (TRS:711).

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Tagalog: Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-418-1622 (TRS:711).

Hindi: �ह◌◌द�
ध◌ य◌◌ न द�: य�द आप �ह◌ द� ब◌◌ लत◌ ह� त आपक◌◌ �लए म फ्त म� भ◌ ष◌◌ सह◌◌ यत स◌ व◌◌ ए◌ उपलब◌ ध ह� I1-855-418-1622
(TRS:711) . पर कॉल कर� I

Serbo-Croatian: Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.
Nazovite 1-855-418-1622 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian: Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-855-418-1622 (телетайп: TRS:711).

Nepali: न◌ प◌ ल�
ध◌ य◌◌ न �दन◌ ह◌◌ स: ◌◌ तप◌◌ इ�ल◌◌ न◌ प◌◌ ल� ब◌◌ ल◌ नह◌ ◌ न◌◌ छ भन◌ तप◌◌ इ�क◌◌ �न�◌◌◌◌ म◌ त भ◌ ष◌ सह◌◌ यत स◌ व◌◌ ह� �न◌◌ शल◌◌◌ क�पम◌ उपलब◌ ध छ I फ◌ न गनह र◌ ◌◌ स◌◌ 1-855-418-1622 (�ट�टव◌◌ इ: TRS:711 I

Persian: فارسی
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-855-418-1622 (TRS:711). با تماس بگیرید

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 855-418-1622 We can connect you with the free help or service you need. (For TRS call: 711)

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TennCare QUEJA DE DISCRIMINACIÓN

Las leyes federales y estatales no permiten que el Programa TennCare lo trate de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley**. ¿Piensa que ha sido tratado de manera diferente por estas razones? Use estas hojas para presentar una queja a TennCare.
Es obligatorio proporcionar la información marcada con un asterisco (*). Si necesita más espacio para decirnos lo que pasó, use otras hojas de papel y envíelas con su queja.

1. * Escriba su nombre y dirección.

Nombre:

____

Dirección:

____

Código postal: ____

Teléfono: Hogar: (_____)_________________Trabajo o Celular:
(_____)____________________________

Dirección de correo electrónico: _________________________
Nombre del MCO/plan de seguro médico:

____

2. *¿Está usted presentando esta queja en nombre de otra persona? Sí:______No:________
Si respondió Sí, ¿quién piensa usted que fue tratado de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley?**

Nombre:

____

Dirección:____

Código postal_________Teléfono: Hogar: (____)_________Trabajo o Celular: (_
____________________)___________________

¿Qué relación tiene usted con esta persona (cónyuge, hermano,

amigo)?____

Nombre del MCO/plan de seguro médico de esa persona:

____

3. * ¿Cuál parte del Programa TennCare cree que lo trató de una manera diferente?

Servicios médicos_____ Servicios dentales_____ Servicios de farmacia______

Servicios y apoyos de largo plazo______ Servicios de elegibilidad_____Apelaciones_______

DentaQuest LLC January 1, 2022
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4. * **¿Por qué cree que lo trataron de una manera diferente?** Fue a causa de su
Lugar de nacimiento_____ Color de la piel_____Sexo______ Edad_____
Raza____

Religión____Otra cosa________________________
Discapacidad_____

5. **¿Cuál es la mejor hora para llamarlo acerca de esta queja?**

____

6. * **¿Cuándo sucedió esto? ¿Sabe la fecha?**

Fecha en que comenzó:__________________Última fecha en que sucedió:__________________

7. **Las quejas deben reportarse no más de 6 meses de la fecha en que piensa que fue tratado de una manera diferente.** Si tiene una causa justificada (como enfermedad o fallecimiento en la familia), puede reportar su queja más de 6 meses después.

____

____

8. * **¿Qué sucedió?** ¿Cómo y por qué piensa que pasó? ¿Quién lo hizo? ¿Piensa que alguna otra persona también fue tratada de una manera diferente? Si necesita más lugar, puede escribir en otra(s) hoja(s) y enviarlas con estas hojas.

____

____

9. **¿Alguien vio cómo lo trataban de una manera diferente?** Si es así, por favor, proporcione la siguiente información sobre esa persona:

Nombre Dirección Teléfono

____

____

10. **¿Tiene usted más información que nos desee dar?**

____

____

____

11. ***No podemos aceptar ninguna queja que no esté firmada**. Por favor, escriba su nombre y la fecha en la línea de abajo. ¿Es usted el Representante Autorizado de la persona que piensa que fue tratada de manera diferente? Firme abajo. Como el Representante Autorizado, usted debe tener un comprobante de que puede actuar en nombre de esta persona. Si el paciente es menor de 18 años de edad, uno de los padres o tutor debe firmar en su nombre.
Declaración: *Declaro que la información presentada en esta queja es verídica y correcta y doy mi autorización para que TennCare investigue mi queja.*

(Firme aquí si usted es la persona de quien trata esta queja) (Fecha)

____

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____

(Firme aquí si usted es el Representante Autorizado) (Fecha)

¿Está usted reportando esta queja en nombre de otra persona pero usted **no** es el Representante Autorizado de la persona? Firme abajo. **La persona para quien usted está reportando esta queja debe firmar arriba o debe decirle a su plan de seguro médico o a**

TennCare que está bien que él/ella firme en su lugar. Declaración: *Afirmo que la información contenida en esta queja es verdadera y correcta y doy mi permiso para que TennCare se comunique conmigo acerca de esta queja.*

____

(Firme aquí si está reportando en nombre de otra persona) (Fecha)

¿Es usted ayudante de TennCare o del MCO/plan de seguro médico y está ayudando al miembro de buena fe a presentar la queja? Si es así, por favor firme abajo:

____

(Firme aquí si usted es ayudante de TennCare o del MCO/plan de seguro médico) (Fecha)

Está bien que reporte una queja a su MCO/plan de seguro médico o a TennCare. La información contenida en esta queja se trata de manera privada. Los nombres y otros datos sobre las personas que aparecen en esta queja sólo se divulgan cuando es necesario. Por favor, envíe una hoja de Autorización para Divulgar Información con su queja. Si está presentando esta queja en nombre de otra persona, pídale a la persona que firme la hoja de Autorización para Divulgar Información y envíela por correo con esta queja. Conserve una copia de todo lo que envíe. Envíe las hojas firmadas de la Queja **y la** Autorización para Divulgar

Información a:

TennCare OCRC

310 Great Circle Road, 3rd Floor
Nashville, TN 37243

Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TRS gratis, marque el 711

Correo electrónico: HCFA.fairtreatment@tn.gov

También puede llamarnos si necesita ayuda con esta información.

TennCare Autorización para Divulgar Información

Para investigar su queja, es posible que TennCare y su MCO/plan de seguro médico tengan que divulgar su nombre u otra información sobre usted a otras personas o agencias importantes en esta queja.

Para acelerar la investigación de su queja, lea, firme y envíe por correo una copia de esta Autorización para Divulgar Información con su queja. Por favor, conserve una copia para usted.

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• Entiendo que durante la investigación de mi queja TennCare y

____(escriba en la línea el nombre de su MCO/plan de seguro médico) posiblemente tengan que dar mi nombre u otra información sobre mí a otras personas o agencias. Por ejemplo, si reporto que mi doctor me trató de manera diferente debido al color de mi piel, es posible que mi MCO/plan de seguro médico tenga que hablar con mi doctor.

• Usted no tiene que estar de acuerdo en divulgar su nombre u otra información. No siempre se necesita para investigar una queja. Aunque no firme la autorización trataremos de investigar su queja. Pero, si usted no está de acuerdo en permitirnos usar su nombre u otros detalles, eso podría limitar o detener la investigación de su queja. Y, tal vez tengamos que cerrar su caso. Sin embargo, antes de cerrar su caso, si no podemos seguir investigando su queja porque usted no firmó la autorización, podríamos comunicarnos con usted para preguntarle si quiere firmar una autorización para que la investigación pueda continuar.

Si usted está presentando esta queja para otra persona, necesitamos que esa persona firme la Autorización para Divulgar Información. ¿Está firmando esto en la capacidad de Representante Autorizado? Si es así, también debe darnos una copia de los documentos que lo nombran como Representante Autorizado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a TennCare para que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a mi MCO/plan de seguro médico que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

Esta Autorización para Divulgar Información tiene vigencia hasta el resultado final de su queja. Usted puede cancelar su autorización en cualquier momento llamando o escribiendo a TennCare o a su MCO/plan de seguro médico sin cancelar su queja. Si cancela su autorización, la información ya divulgada no se puede hacer desconocer.

Firma:_______________________________________Fecha:________________

Nombre (en letra de imprenta):________

____ Dirección:_____________

____ Teléfono: _____________

____

¿Necesita ayuda? ¿Quiere reportar una queja? Por favor llame o envíe una queja y una Autorización para Divulgar Información completadas y firmadas a:

TennCare OCRC Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673

310 Great Circle Road, 3rd Floor Para TRS gratis, marque el 711 y pida el 855-857-1673

Nashville, TN 37243 Correo electrónico: HCFA.fairtreatment@tn.gov

¿Necesita ayuda gratuita con esta carta?

Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

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DentaQuest

Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-855-418-1622 (TRS:711).

Kurdish: کوردی
ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ **1-855-418-1622** بەردەستە. پەیوەندی بە **(TRS:711)..** بکە

Arabic: العربية
ملحوظة: اذا كنت تتكلم اللغة العربية فإن خدمات المساعدة اللغوية متوفرة لك مجانا. اتصل برقم **1-855-** **(TRS:** رقم هاتف الصم والبكم **711)** **418-1622:**

Chinese: 繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-418-1622 (TRS:711).**

Vietnamese: Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số
1-855-418-1622 (TRS:711).

Korean: 한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-418-1622 (TRS:711).번으로 전화해 주십시오.

French: Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-418-1622 (TRS:711).

Amharic: አማርኛ
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ወደ ሚከተለው ቁጥር ይደውሉ **1-8855-418-1622** (መስማት ለተሳናቸው:**TRS:711**).

Gujarati: �જરાતી
�ચ ના: જ◌◌ તમ◌◌ �જ રા◌◌ત◌◌◌◌◌ી બ◌ લત◌◌◌ા હ◌ , ત◌◌ િ◌◌◌◌ન:�લ◌્◌ ક
ભ◌◌ાષ◌◌ા સહ◌◌◌ાય સ◌◌ વ◌◌◌ાઓ તમ◌◌◌ાર◌◌ા મ◌◌ાટ� ઉપલબ◌્ છ◌ . ફ◌ ન કર◌
1-855-418-1622 (TRS:711) .

Laotian: ພາສາລາວ
ໂປດຊາບ: ຖ້ າວ້ ້ າ ທ່ ້ າພ ້ ວ້ າພາສາ ລາວ, ການ້ ້ ປ່ ້ ລການຊ່ ້ ວຍ ້ ທ່ ອດ ້ ້ າບພາສາ, ໂດຍ ້ ້ ້ ້ ປເສ້ ້ ງຄ່ ້ າ, ແມ່ ້ ນ້ ້ ມ

German: Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-418-1622 (TRS:711).

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Tagalog: Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-418-1622 (TRS:711).

Hindi: �ह�द�

ध य न द�: य�द आप �ह द� ब लत ह� त आपक �लए मफ त म� भ ष सह यत स व ए उपलब ध ह� ।1-855-418-1622 (TRS:711) . पर कॉल कर� ।

Serbo-Croatian: Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.
Nazovite 1-855-418-1622 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian: Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-855-418-1622 (телетайп: TRS:711).

Nepali: न प ल�

ध य न �दन ह स: तप इ�ल न प ल� ब ल नह न छ भन तप इ�क �न� म त भ ष सह यत स व ह� �न शल क�म उपलब ध छ । फ न गनह र स 1-855-418-1622 (�ट�टव इ: TRS:711 ।

Persian: فارسی
توجه: اگر هب زبان فارسی گفتگو یم کنید، تسهیلات زبانی بصورت رایگان 1-855-418-1622
برای امشد فراهم یم باشد .اب تماس بگیرید(TRS:711).

• ¿Necesita ayuda para hablar con nosotros o para leer lo que le enviamos?

• ¿Tiene alguna discapacidad y necesita ayuda para su cuidado o para tomar parte en uno de nuestros programas o servicios?

• ¿O tiene más preguntas sobre su atención médica? Llámenos gratis al 1-855-259-0701. Podemos conectarlo con la ayuda o servicio gratuito que necesite.

(Para el sistema TTY (Para los sordos) llame al: 1-800-848-0298)

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TennCare Discrimination Complaint

أن يقوم بالتمييز ضدك بسبب **عرقك أو لونك أو مكان ميلادك، أو عجزك، أو** TennCare لا حمست القوانين الاتحادية وقوانين الولايات لبرنامج
عمرك،أو جنسك، أو دينك، أو أي ةئف أخرى اهيمحيا القانون .هل تعتقد أنك قد تعرضت للتمييز لهذه الأسباب؟ استخدم تلك الصفحات للإبلاغ
TennCare عن أي شكوى إلى برنامج .
يتعين عليك الإجابة ىلع المعلومات التي تحمل ةملاع ةمجن .(*)وإن احتجت إلى المزيد من المساحة لتخبرنا امب حدث، فاستخدم أوراق أخرى
وارسلها عم شكوتك.

.اكتب اسمك وعنوانك* 1 .
العنوان :الاسم الرمز : البريدي

(____) العمل أو المحمول :المنزل الهاتف)____الإلكتروني :البريد (

اسم منظمة الرعاية المدارة \خطة الصحة:

هل غلبت عن هذه الشكوى من أجل شخص آخر؟ نعم : لا_ * **2.** هو الشخص تعرض:
للتمييز بسبب **العرق، أو اللون، أو مكان الميلاد، أو العجز\الإعاقة، أو العمر، أو الجنس، أو**
الدين، أي ةئف أخرى اهيمحيا القانون؟
الاسم :
:العنوان
الرمز البريدي

(______ الهاتف :المنزل) ______________________) المحمول
ام هي صلتك بذلك الشخص)زوجة، أخ، صديق(؟
خطة الصحة الخاصة بذل الشخصك\اسم منظمة الرعاية المدارة

.TennCare3 :*أي جزء من برنامج تعتقد أنه قام بالتمييز ضدك
الخدمات الطبية خدمات طب الأسنان_ الخدمات الصيدلية_

الدعم والخدمات طويلة المدى خدمات الأهلية_ الالتماسات_

كيف تعرضت للتمييز؟ هل كان بسبب* 4.
عرقك مكان ميلادك _ لونك عمرك

عجزك دينك_ سبب آخر
ام هو أنسب وقت للتحدث إليك بشأن هذه الشكوى؟5.

ىتم حدث ذلك لك؟ هل تعلم التاريخ؟* 6
تاريخ بداية الحدث__________تاريخ آخر مرة حدث ذلك **.يتعين عليك الإبلاغ عن الشكوى:**
.قبل 6 أشهر من تاريخ اليوم الذي تعرضت هيف للتمييز 7
يجوز لك الحصول ىلع أكثر من 6 أشهر للإبلاغ عن الشكوى إذا كانت هناك أسباب قوية لانتظارك كل هذه الفترة)مثل ةلاح وفاة يف عائلتك أو
مرض ام(.

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ما الذي حدث؟ كيف ولماذا تعتقد أن ذلك حدث؟ من قام بذلك؟ هل تعتقد أن أي هناك شخص آخر تعرض للتمييز؟ يمكنك الكتابة * 8
على المزيد
من الورق وإرسالها مع هذه الصفحات إذا احتجت لمزيد من المساحة.

هل هناك شاهد على ذلك التمييز؟ إن كان الأمر كذلك، يرجى إخبارنا ب 9:
الاسم العنوان الهاتف

هل لديك مزيد من المعلومات تريد أن تطلعنا عليها؟ . 10

لا نستطيع استلام شكوى غير موقعة. يرجى كتابة اسمك والتاريخ على السطر أدناه. هل تعد الشخص الذي تظن أنه لا مخول *. 11 تعرض
للتمييز؟ يرجى توقيع اسمك أدناه. وبصفتك الممثل المخول، فلابد أن يكون لديك دليل على أنه يمكنك التصرف نيابة عن ذلك الشخص . إذا كان
المريض أصغر من 18 عام، فيتعين على الوالد و الوصي التوقيع للقاصر. بيان :أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية
وصحيحة وأعطي برنامج موافقتي للتحقيق في شكوتي؟ ***TennCare***

)التاريخ ()وقع اسمك هنا إن كنت أنت الشخص الذي تعرض له هذه الشكوى(
)وقع
هنا إن كنت
(الممثل المخول( )التاريخ
يتعين على الشخص الذي هل تبلغ عن هذه الشكوى لشخص آخر ولكنك لست الممثل المخول للشخص؟ يرجى توقيع اسمك **بالأسفل**
إذا بلغت عن هذه الشكوى هل التوقيع أعلاه أو إخبار خطة الصحة الخاصة به TennCare. هنا\أو هنا. لا يوجد مانع من قيامك بالتوقيع هل أو برنامج
TennCare بيان :أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج موافقتي للاتصال بي بشأن تلك
الشكوى.

(وقع هنا إن كنت تبلغ عن هذه الشكوى من أجل شخص آخر( )التاريخ)
هل أنت مساعد من TennCare منظمة الرعاية المدارة التي تساعد العضو نيابة طبية لملء تلك الشكوى؟ إن كان\ أو خطة الصحة برنامج
يرجى التوقيع بالأسفل من) :الأمر
كذلك، هنا إن كنت مساعد
وقع
(أو من خطة الصحة\ منظمة الرعاية المدارة) (التاريخ TennCare
ويتم التعامل مع المعلومات TennCare. لا يوجد مانع من الإبلاغ عن أي شكوى لخطة الصحة\ منظمة الرعاية المدارة الخاصة بك أو برنامج
المتضمنة في تلك الشكوى بسرية. ولا يتم مشاركة الأسماء وأي معلومات أخرى بشأن الأشخاص المستخدمين في تلك الشكوى إلا عند الحاجة .
يرجى إرسال اتفاق الكشف عن المعلومات موقعا مع شكوتك. وفي حال تقديمك لتلك الشكوى نيابة عن شخص آخر، فيتعين على هذا الشخص
توقيع اتفاق الكشف عن المعلومات وارسالها مع تلك الشكوى. احتفظ بنسخة من كل شيء ترسله. يرجى ارسال بريد أو بريد إلكتروني بالشكوى

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:الموقعة والكاملة وصفحات اتفاق الكشف عن المعلومات الموقع لنا على
TennCare, Office of Civil Rights Compliance

310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

امكـ يمكنك الاتصال انبـ إن احتجت للمساعدة بخصوص تلك المعلومات.

TennCare Agreement to Release Information

TennCare قيحتلل يـف شكوتك، قد يحتاج برنامج أو خطة الصحة\ منظمة الرعاية المدارة الخاصة بك لإخبار الأشخاص الآخرين أو الوكالات
الضروريين لتلك الشكوى عن اسمك أو معلومات أخرى عنك.

برجاء.لتسريع التحقيق يـف شكوتك، برجاء قراءة، وتوقيع، وإرسال بريد ةخسنبـ من اتفاق الكشف عن المعلومات عمـ شكوتك الاحتفاظ ةخسنبـ
لنفسك .

و TennCare • أدرك أنه أثناء التحقيق يـف شكوتي، قد يحتاج برنامج_اكتب اسم خطة الصحة\ منظمة الرعاية ،المدارة الخاصةبك)
ىلع السطر (لإخبار الأشخاص يمسابـ أو معلومات أخرى يـنأشبـ لأشخاص أو وكالات أخرى .ىلع سبيل المثال يـفحال إبلاغي
أنني قد تعرضت للتمييز من طبيبي بسبب لوني، فقد تحتاج خطة الصحة\ منظمة الرعاية المدارة الخاصة يـبـ إلى
التحدث عمـ طبيبي.

•
يتعين عليك الموافقة ىلع الكشف عن اسمك أو معلومات أخرى .لا يلزم دائم ا التحقيق يـف شكوتك .إذا لم توقع ىلع الكشف فسنظل لا،

نحاولالتحقيق يـف شكوتك .ولكن، إذا لم توافق ىلع السماح انلـ باستخدام اسمك أو تفاصيل أخرى، فقد يحد هذا أو يوقف التحقيق يـف
شكوتك .وقد نضطر إلى إغلاق حالتك .ومع ذلك، قبل أن قلـغنـ حالتك إذا لم يعد ممك انـ التحقيق يـف شكوتك لأنك لم توقع .ىلع
الكشف، فقد نتصل بك لمعرفة امـ إذا كنت ترغب يـف التوقيع ىلع الكشف يـكلـ يستمر التحقيق
الشكوى من أجل شخص آخر، فلابد لذلك الشخص أن يوقع ىلع اتفاق الكشف عن المعلومات .هل توقع ىلع
هذه .ؤصفتك ممثل مخول؟ عفليك أيضا أن تعطينا نسخة من الوثاقئـ التي تعد بموجبها ممثلا
مخولا

وأوافق ىلع أن.عند توقيعي ىلع اتفاق الكشف عن المعلومات، أوافق ىلع أنني قد قرأت وفهمت حقوقي المنصوص اهيلع أعلاه
TennCare يخبر برنامج الناس يمسابـ أ و أي معلومات أخرى يـنع لأشخاص أو وكالات أخرى ضروريين لتلك الشكوى خلال
التحقيق والنتائج.

عند توقيعي ىلع اتفاق الكشف عن المعلومات، أوافق ىلع أنني قد قرأت وفهمت حقوقي المنصوص اهيلع أعلاه .أوافق ىلع أن
تخبر خطة الصحة\ منظمة الرعاية المدارة الخاصة يـبـ الناس يمسابـ أو أي معلومات أخرى يـنع لأشخاص أو وكالات أخرى
ضروريين لتلك الشكوى خلال التحقيق والنتائج.

يعد اتفاق الكشف عن المعلومات موضع تنفيذ ىتح النتيجة النهائية لشكوتك .بإمكانك إلغاء اتفاقك يـف أي وقت من خلال الاتصال أو
TennCare راسلة أو خطة الصحة\ منظمة الرعاية المدارة الخاصة بك بدون إلغاء شكوتك .وإذا قمت بإلغاء ذلك الاتفاق، لاف يمكن
للمعلومات التي تمت مشاركتها بالفعل أن تعود.

مجهولة:التوقيع التاريخ :
الاسم)برجاء الطباعة(:الهاتف:____________العنوان **تحتاج للمساعدة؟** هل تريد :
الإبلاغ عن أي شكوى؟ برجاء الاتصال أو إرسال بريد يحتوى ىلع الشكوى **الموقعة** والكاملة واستمارة
اتفاق الكشف عن المعلومات الموقع إلى العنوان التالي:

TennCare OCRC
310 Great Circle Road, 3W
Nashville, TN 37243
البريد الإلكتروني : HCFA.fairtreatment@tn.gov
أو على الهاتف المجاني :1673 -507-615- الهاتف: 1-855-857- 1 6474
TRS لخدمة ترحيل الاتصالات -855-857 ، اطلب 711 ثم اسأل عن 167

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Agreement to Pay Non-Covered Services

Patient Name:____

Member (Medicaid) ID:____

Guarantor Name:____

Relationship to patient:____

Not all dental services are covered by the TennCare Dental Program. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above-named patient, but are not covered services:

Non-Covered Services

Code	Description
__________	______________________________________
__________	______________________________________
__________	______________________________________
__________	______________________________________

I understand that the above services are not covered by the TennCare Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this is responsibility and will pay the dentist when I receive his/her billing statement.

______________________________ ______________
Guarantor Signature Date

Guarantor Address:

____
Street, Apt #

____
City, State, Zip

Guarantor Phone:

______________________________ ______________
Home Cell Work

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ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for

Predetermination/Preauthorization EPSDT /TitleXIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTALBENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5 -11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender F M

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5

Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender M F

15. Policyholder/Subscriber ID(SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

Self Spouse DependentChild Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A____ B____ C D

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

ANCILLARY CLAIM/TREATMENT INFORMATION

DentaQuest LLC January 1, 2022
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36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X Patient/Guardian Signature Date	38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X Subscriber Signature Date	40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
	42. Months of Treatment Remaining / 43. Replacement of Prosthesis No Yes (Complete44)	44. Date of Prior Placement (MM/DD/CCYY)
	45. Treatment Resulting from Occupational illness/injury Auto accident Other accident	
	46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**
48. Name, Address, City, State, Zip Code	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X Signed (Treating Dentist) Date
	54. NPI / 55. License Number
	56. Address, City, State, Zip Code / 56a. Provider Specialty Code
49. NPI / 50. License Number / 51. SSN or TIN	
52. Phone Number ( ) - / 52a. Additional Provider ID	57. Phone Number ( ) - / 58. Additional Provider ID

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health

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conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer (“A” through
“D” as applicable from Item 34a) Item 34 –
Diagnosis Code List Qualifier (B for ICD-9-CM;
AB for ICD-10-CM)
Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter “A”)

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing

Facility; 32 = Nursing Facility The full list is available online at

“www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf”

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as “Dentist” may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-edi.com/codes/taxonomy”

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Initial Clinical Exam Form

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME ______________________________
Last First Middle

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B L

A B C D E F G H I J

RIGHT LEFT

T S R Q P O N M L K

L B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST ______________________ DATE

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Recall Examination Form

PATIENT'S NAME

____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY_______________________________

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS		B/P		RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: ____

____

____

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Authorization for Dental Treatment

I hereby authorize Dr.______________________________and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s):____

Tooth Number(s):____

Date:________________________________

Dentist:______________________________

Patient Name:_________________________

Legal Guardian/

Patient Signature:______________________

Witness:______________________________

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Medical and Dental History

Patient Name:____Date of Birth:__________________

Address:____

Why are you here today? _______________________________

Are you having pain or discomfort at this time? Yes/No_

If yes, what type and where?____

Have you been under the care of a medical doctor during the past two years? Yes/No _

Medical Doctor's Name:

Address ____

Telephone:____

Have you taken any medication or drugs during the past two years? Yes/No

Are you now taking any medication, drugs, or pills? Yes/No_

If yes, please list medications:____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

Yes/No_

If yes, please list:____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest,

shortness of breath, or because you are very tired? Yes/No_

Do your ankles swell during the day? Yes/No_

Do you use more than two pillows to sleep? Yes/No_

Have you lost or gained more than 10 pounds in the past year? Yes/No_

Do you ever wake up from sleep and feel short of breath? Yes/No_

Are you on a special diet? Yes/No_

Has your medical doctor ever said you have cancer or a tumor? Yes/No_

f yes, where? ____

Do you use tobacco products (smoke or chew tobacco)? Yes/No_

If yes, how often and how much?____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? Yes/No

Do you have or have you had any disease, or condition not listed? Yes/No_

If yes, please list:____

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Indicate which of the following you have had or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	Yes/No_	Stroke	Yes/No_	Hepatitis C	Yes/No_
Heart Failure	Yes/No_	Kidney Trouble	Yes/No_	Arteriosclerosis (hardening of arteries)	Yes/No_
Angina Pectoris	Yes/No_	High Blood Pressure	Yes/No_	Ulcers	Yes/No_
Congenital Heart Disease	Yes/No_	Venereal Disease	Yes/No_	AIDS	Yes/No_
Diabetes	Yes/No_	Heart Murmur	Yes/No_	Blood Transfusion	Yes/No_
HIV Positive	Yes/No_	Glaucoma	Yes/No_	Cold sores/Fever blisters/ Herpes	Yes/No_
High Blood Pressure	Yes/No_	Cortisone Medication	Yes/No_	Artificial Heart Valve	Yes/No_
Mitral Valve Prolapse	Yes/No_	Cosmetic Surgery	Yes/No_	Heart Pacemaker	Yes/No_
Emphysema	Yes/No_	Anemia	Yes/No_	Sickle Cell Disease	Yes/No_
Chronic Cough	Yes/No_	Heart Surgery	Yes/No_	Asthma	Yes/No_
Tuberculosis	Yes/No_	Bruise Easily	Yes/No_	Yellow Jaundice	Yes/No_
Liver Disease	Yes/No_	Rheumatic fever	Yes/No_	Rheumatism	Yes/No_
Arthritis	Yes/No_	Epilepsy or Seizures	Yes/No_	Fainting or Dizzy Spells	Yes/No_
Allergies or Hives	Yes/No_	Nervousness	Yes/No_	Chemotherapy	Yes/No_
Sinus Trouble	Yes/No_	Radiation Therapy	Yes/No_	Drug Addiction	Yes/No_
Pain in Jaw Joints	Yes/No_	Thyroid Problems	Yes/No_	Psychiatric Treatment	Yes/No_
Hay Fever	Yes/No_	Hepatitis A (infectious)	Yes/No_		Yes/No_
Artificial Joints (Hip, Knee, etc.)	Yes/No_	Hepatitis B (serum)	Yes/No_		Yes/No_

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For Women Only:

Are you pregnant? Yes/No_

If yes, what month?____

Are you nursing? Yes/No_

Are you taking birth control pills? Yes/No_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature:______________________________Date:___________________________

Dentist's Signature:_____________________________Date:___________________________

Review Date	Changes in Health Status	Patient's Signature	Dentist's Signature

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077

Section 1: Current Information - *Complete for ALL Requests - Asterisk denotes required fields*

Change Effective Date *(Required)* :

*Provider Last Name | *Provider First Name

*Individual National Provider Identifier (NPI) #

Date of Birth | Social Security # | Gender

*Specialty | *Personal E-Mail

Requestor Information

*Requestor Name | *Title

*Requestor Contact Information *(Phone or E-mail)*

Section 2: Type of Update - Check all that Apply - *Complete for ALL Requests* - For Questions contact your Provider Engagement Representative or Customer Service

- ☐ Business (Tax ID) - Add/ Term/ Update - Complete Sections 1, 7 and 8
- ☐ Credentialing Correspondence Change/Update - Complete Sections 1 and 5
- ☐ EFT/ Payment - Complete Sections 1 and 8
- ☐ License Change - Complete Sections 1 and 4
- ☐ Name Change - Complete Sections 1 and 3
- ☐ Location - Add/ Term/ Update - Complete Sections 1 and 6
- ☐ Termination Request - Complete Sections 1 and 9

Section 3: Name Change - *Attach supporting legal documentation*

New Last Name | New First Name

New Middle Name | New Suffix

Please Note: Before DentaQuest can change your name in our system, your license must reflect the name change.

Section 4: License Change

New Dental License Number | State

New DEA License Number | State

New State Drug License Number | State

New Medicaid License Number | State

Other License Name

Other License Number | State

Section 5: Credentialing Correspondence Change

Credentialing Contact Name

Correspondence Address

City | State | Zip Code

Telephone | Fax

Credentialing E-Mail

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Provider Update Form - Provider Operations

Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add ☐ Term ☐ Update

Tax ID Number ______ Medicaid ID (if applicable) ______

Location Name ______

Location Address ______

City ______ State ______ Zip Code ______

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone ______ Fax ______

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail ______

Office Hours Monday - ______ Tuesday - ______

Wednesday - ______ Thursday - ______

Friday - ______ Saturday - ______

Sunday - ______ Ages Minimum ______ Ages Maximum ______

☐ Primary Location ☐ Handicapped Accessible

Office Languages ______

Section 7: Business - (Tax ID) Add/ Term/ Update - *Updated Contract, W9 and Disclosure of Ownership required for all Adds and Updates - W9 and Disclosure of Ownership Attached*

☐ Add ☐ Term ☐ Update

Old/ Current Tax ID Number ______ New Tax ID Number ______

Business Name ______

Business Address ______

City ______ State ______ Zip Code ______

Telephone ______ Fax ______

Office E-Mail ______

Group NPI ______

Please Note: DentaQuest requires a Group NPI for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?
If yes, please provide a date of when all claims will be submitted by: ______ ☐ Yes ☐ No

Section 8: EFT/ Payment

Tax ID Number ______

Payment Address ______

City ______ State ______ Zip Code ______

☐ Add EFT ☐ Cancel EFT ☐ Change EFT

Please Note: The DentaQuest EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached)

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Provider Update Form - Provider Operations

Section 9: Termination Request

☐ Term Provider at Location Listed Below | Tax ID Number

Please attach document with any additional locations to be termed.

☐ Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐ Term Business | Tax ID Number

Please attach a list of providers and locations that need to be terminated.

Term Reason/ Comments

Location Name

Location Address

City | State | Zip Code

Section 10: Type of Update - Check all that Apply - *Complete for ALL Requests - Internal Use ONLY*

- ☐ Product(s) Add/ Update/ Term- Complete Sections 1, 10 and Notes
- ☐ Claims Issue(s) - Complete Sections 1, 10 and Notes
- ☐ Dental Home - Complete Sections 1, 10 and Notes
- ☐ Fee Schedule Add - Complete Sections 1, 10 and Notes
- ☐ Fee Schedule Change - Complete Sections 1, 10 and Notes
- ☐ Provider Rule Add - Complete Sections 1, 10 and Notes
- ☐ Provider Rule Change - Complete Sections 1, 10 and Notes

Notes

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Provider Update Form - Provider Operations

Additional Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add ☐ Term ☐ Update

Tax ID Number ____ Medicaid ID (if applicable) ____

Location Name ____

Location Address ____

City ____ State ____ Zip Code ____

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone ____ Fax ____

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail ____

Office Hours Monday - ____ Tuesday - ____

Wednesday - ____ Thursday - ____

Friday - ____ Saturday - ____

Sunday - ____ Ages Minimum ____ Ages Maximum ____

☐ Primary Location ☐ Handicapped Accessible

Office Languages ____

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AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST, LLC

***Indicates Required Field. Please print legibly.**

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	
Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	

Provider Identifiers Information			
*Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits		*National Provider Identifier (NPI) Numeric 10 Digits	

Provider Contact Information			
*Provider Contact Name- (Name of contact in provider office authorized to handle EFT issues		Title	
*Telephone Number		*Email Address	

Financial Institution Information			
*Financial Institution Name			
Financial Institution Address			
*Street		*City	
*State/Province		*Zip Code/Postal Code	
Financial Institution Telephone Number			
*Financial Institution Routing Number (Numeric 9 Digits)		*Type of Account at Financial Institution (e.g., Checking, Saving)	
*Provider's Account Number with Financial Institution		*Account Number Linkage to Provider Identifier – Select One	Provider TIN ☐ Provider NPI ☐

Submission Information			
***Reason for Submission** Select One	**New Enrollment** ☐	**Change Enrollment** ☐	**Cancel Enrollment** ☐
Include with Enrollment Submission	Voided Check A voided check is attached to provide confirmation of Identification/Account Numbers		

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As a convenience to me, for payment of services or goods due to me, I hereby request and authorize **DentaQuest, LLC** to credit my bank account via Direct Deposit for the agreed upon dollar amounts and dates. I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree **DentaQuest, LLC** shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that **DentaQuest, LLC's** treatment of each such credit entry, and the rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, **DentaQuest, LLC** shall be under no liability whatsoever.

Submission Date	Authorized Signature
Requested EFT Start/Change/Cancel Date	Printed Name of Person Submitting Enrollment
	Printed Title of Person Submitting Enrollment

APPENDIX

Additional Information to assist with completion of this EFT/ACH Enrollment Form and the EFT/ACH banking process.

Please note the following *IMPORTANT* information:

- We are required to inform you that you MUST contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
- **You MUST attach a voided check from your account.**

ACCOUNT HOLDER INFORMATION:

Personal Checking Example

Routing Number Account Number Check Number

Business Checking Example

Check Number Routing Number Account Number

Questions?

You may send your completed form, as well as any questions regarding the status of your EFT enrollment, to the fax number or email address provided below:

Fax: (262)241-4077
Email: StandardUpdates@dentaquest.com

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Disclosure of Ownership and Control Interest Statement

Purpose of the Form: Completion and submission of this form is a condition of participation in Medicare, Medicaid, Social Security Block Grant or State Children's Health Insurance Program (CHIP). This form must be completed every three years and within 35 days of information changes, to be in compliance with 42 CFR §457.935, 42 CFR §§455.104, 105 and 106. A form is required for each Tax ID associated with a Disclosing Entity or Provider/ Provider Group.

Please answer all question as of the current date. Do not leave any questions or sections blank. If the requested information does not apply, please answer with a NA. There are questions that, when answered 'yes', require additional information be provided. If a correction is made to the document, the error needs to be lined out, dated, and initialed.

Important Note: The entity name in Section 1 of the Disclosure of Ownership and Conflict of Interest Form must match the information on the Contract and W9 that we and the IRS currently have on file for you or your organization.

Anyone fitting the following definitions of Managing Employee, Direct Ownership, Indirect Ownership, or Controlling Interest must be listed in 3a and potentially 3d. Social Security Numbers and Date of Birth must be provided for all persons with ownership, controlling interest or are a managing employee to comply with federal regulations (Sect. 4313 of the Balanced Budget Act of 1997, amended Sect. 1124 and Federal Register Vol. 76 No. 22 for further information). This includes Board Members, Administrators, Director, or other individual who has operation or managerial control, or who directly or indirectly conducts day to day operation of the business.

Definitions/ Information
Disclosing Entity: a Medicaid provider (other than an individual practitioner or group of individual practitioners), or fiscal agent. Normally these are corporations or partnerships where there are owners, officers, partners, or managing employees who run the company. Disclosures on these individuals are captured as these parties are considered "behind the scenes" and direct how the organization will operate. They are responsible for decisions made in policies and procedures for how services will be provided and for billing.
Direct Ownership Interest: possession of stock, equity in capital or any interest in the profits of the Business Entity. A Business Entity is defined as a Medicare and/or Medicaid provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid and/or Medicare Program.
Indirect Ownership Interest: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity with ownership of 5 percent or more. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity.
Managing Employees: people who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations or head up the business functions of a Provider Entity. State and federal requirements prohibit a Medicaid MCO from contracting with a Provider Entity whose Managing Employees are excluded from federal healthcare programs.
Ownership Interest: possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest: a person or corporation that has (a) an ownership interest totaling 5% or more in a disclosing entity; (b) an indirect ownership interest equal to 5% or more in a disclosing entity; (c) a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; (d) an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; or (e) is an officer or director of a Disclosing Entity that is organized as a corporation or a partner in a disclosing entity that is organized as a partnership.

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Disclosure of Ownership and Control Interest Statement

This document MUST be completed and signed by an Owner of the Business Entity.

The Disclosure of Ownership is a Center for Medicare and Medicaid Services (CMS) and Client Required document to obtain during the contracting/credentialing process. If this documentation is not received, the credentialing process will be delayed. *If there are multiple Service Offices associated with this Business Entity, please attach a complete list of ALL Service Offices including their address.*

Section 1

Completion and submission of this form is a condition of participation in any program established by Medicaid or Medicare only. One full and accurate disclosure of ownership is required for each Business Entity. Failure to submit the requested information will result in refusal to participate in the Network or in termination of an existing agreement. If there are any changes in the ownership an updated form must be submitted within 35 days.

Identifying Information

When completing this section please use the Name of the Entity on file with the IRS, not a "DBA", Doing Business As Name.

Name of Entity
Tax ID
Telephone Number
Street Address
City
State
Zip
County

Section 2

Answer the following questions by checking "Yes" or "No".

If any of the questions are answered "Yes", list the names and addresses if the individuals or corporations on a separate page.

2a. Are there any individuals or organizations that have a direct or indirect ownership or controlling interest of 5% or more in the Business Entity that have been convicted of a criminal offense related to the involvement of persons in any of the programs under Medicaid and Medicare Programs? ☐ Yes ☐ No

2b. Have any directors, officers, agents, or managing employees of the Business Entity ever been convicted of a criminal offense related to their involvement in such programs established by Medicaid and Medicare? ☐ Yes ☐ No

2c. Are there any individuals currently employed by the Business Entity in a managerial, accounting, auditing, or similar capacity who were employed by the entity's fiscal intermediary or carrier within the previous 12 months? ☐ Yes ☐ No

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Disclosure of Ownership and Control Interest Statement

Section 3

Owners & Managing Employees

3a. List names, addresses, Dates of Birth and SSN for all Persons with an ownership interest in; or who are Managing Employees of the Disclosing Entity. List any additional names and addresses on a separate page. If more than one individual is reported and any of these persons are related to each other, this must be reported on a separate page. For Persons who are corporations, substitute the corporation's Tax Identification Number (TIN) for the SSN.

Owner/ Managing Employee #1
Name of Person
Date of Birth
SSN
Address
City, State and Zip
Owner/ Managing Employee #2
Name of Person
Date of Birth
SSN
Address
City, State and Zip
Owner/ Managing Employee #3
Name of Person
Date of Birth
SSN
Address
City, State and Zip

3b. Type of Entity – Check one that applies

Please Note: Your selection here MUST match how you are registered with the IRS and the W9 we have on file.

☐ Limited Liability Company (LLC)
☐ S-Corporation
☐ C-Corporation
☐ Sole Proprietor/Single Member LLC
☐ Partnership
☐ Trust/Estate
☐ Government Entity
☐ Other ____

3c. If this Business Entity is a corporation, list names, addresses of the Directors, and EINs for entities, if different than what is listed in 3a.

3d. Are any owners of the Disclosing Entity also owners of ***other*** Medicare/Medicaid facilities, with ***different*** Tax Id's that are different from that listed in section 1? (Example: sole proprietor, partnership or members of Board of Directors.)

☐ Yes ☐ No

If yes, please complete the section below:

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Disclosure of Ownership and Control Interest Statement

Owner/ Entity #1
Name of Individual/ Entity
SSN/ TIN
Address
City, State and Zip
Owner/ Entity #2
Name of Individual/ Entity
SSN/ TIN
Address
City, State and Zip
Owner/ Entity #3
Name of Individual/ Entity
SSN/ TIN
Address
City, State and Zip

Section 4

Answer the following questions by checking "Yes" or "No".
If any of the questions are answered "Yes", list the date of the change.

4a. Has there been a change in ownership or control within the last year? ☐Yes ☐No
If yes, give date: _________

4b. Do you anticipate any change of ownership or control within the year? ☐Yes ☐No
If yes, give date: _________

4c. Do you anticipate filing for bankruptcy within the year? ☐Yes ☐No
If yes, give date: _________

Section 5

5. Is the Disclosing Entity operated by a management company or leased in whole or in part by another organization? ☐Yes ☐No

Section 6

6. Has there been a change in management within the last year? ☐Yes ☐No

(change in Director, a new Administrator, contracting operations of the facility to a management corporation, hiring or dismissing employees with 5% or more interest, or similar change)

Section 7

7a. Is the Disclosing Entity currently chain affiliated? ☐Yes ☐No
If yes, please complete the section below:

Name
EIN
Address
City, State and Zip

7b. If "No", was the Disclosing Entity ever chain affiliated? ☐Yes ☐No

Name
EIN
Address
City, State and Zip

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Disclosure of Ownership and Control Interest Statement
WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE. BY SIGNING BELOW THE NAMED INDIVIDUAL REPRESENTS, WARRANTS AND ACKNOWLEDGES THAT S/HE HAS THE LEGAL AUTHORITY TO BIND THE ABOVE-NAMED ORGANIZATION AND ATTESTS TO THE VALIDITY AND ACCURACY OF THE INFORMATION PRESENTED HEREIN.
Name (Typed)
Title
Signature (this may be an electronic signature provided there is an electronic date and time stamp)
Date

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Form **W-9**
(Rev. December 2014)
Department of the Treasury
InternalRevenueService

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

– –

or

Employer identification number

–

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S.person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

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• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

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4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

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Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)11—

A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a) J—

A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the*

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Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. “Other payments” include payments made in the course of the requester’s trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person’s number must be furnished.

[2] Circle the minor’s name and furnish the minor’s SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the “Business name/disregarded entity” name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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DentaQuest

Request for Transfer of Records

I,____________________________, hereby request and give my permission to

Dr.________________________to provide Dr.___________________________________any and all

information regarding past dental care for______________________________.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

____

____

____

Signed: _____________________________________Date: _______________________(Patient)

Signed:______________________________________Date: ___________________________________
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address:____

Phone ____

DentaQuest LLC January 1, 2022
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APPENDIX B – Covered Benefits

DentaQuest

This section identifies TennCare Program covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:**

855.418.1622

Dental offices are not allowed to charge TennCare Members for missed appointments. TennCare[SM] Members are to be allowed the same access to dental treatment as any other patient in the dental practice. Private reimbursement arrangements may be made only for non- covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth number "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate restorations in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA coded 2140. Furthermore, TennCare will reimburse for the total number of surfaces restored per tooth, per day; (e.g. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration.)

The TennCare claim system can only recognize dental services described using the current American Dental Association CDT code list, or those as defined in this manual. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental
Association 211 East
Chicago Avenue Chicago,
IL 60611

800.947.4746

Furthermore, TennCare subscribes to the definition of services performed as described in the CDT manual.

The benefit table (Exhibit A) is all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage;
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, and
6. any other applicable benefit limitations.

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Exhibit A Benefits Covered for
TN - TennCare Children

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within 30 days will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Reimbursement for procedures provided outside the recommended age limits require documentation of medical necessity such as in a form of a narrative.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Year(s) Per Provider OR Location. Not allowed with routine dental services.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No	One (1) Per Date of Service	
D0230	intraoral - periapical each additional radiographic image	0-20		No		

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Exhibit A Benefits Covered for
TN - TennCare Children

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	2 - 20		No	One of (D0270, D0272, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0274) per 12 Month(s) Per patient.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	
D0340	cephalometric radiographic image	0-20		No		
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	6 - 20		No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	

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Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

Space maintainers are a covered service when indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance and not covered by this Plan.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 20		No	One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Includes additional scaling.	
D1120	prophylaxis - child	0-12		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	4 - 20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1351	sealant - per tooth	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 1 Lifetime Per patient per tooth. Occlusal surface only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1352) per 36 Month(s) Per patient per tooth.	
D1353	Sealant repair - per tooth	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1353) per 1 Lifetime Per patient per tooth.	

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Exhibit A Benefits Covered for
TN - TennCare Children

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1354	interim caries arresting medicament application - per tooth	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Four of (D1354) per 1 Lifetime Per patient per tooth. Limit of 6 teeth per DOS. Only 2 of the 4 per tooth applications can be done within 6 weeks of each other. Not allowed if had D2000 series code on same tooth in prior 12 months. D2000 series code on same tooth not allowed for 4 weeks after D1354 (with exception of D2941 on same DOS as D1354).	
D1510	space maintainer-fixed, unilateral-per quadrant	2-12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1516	space maintainer --fixed--bilateral, maxillary	2-12		No	One of (D1516, D1526) per 1 Lifetime Per patient. Indicate missing tooth numbers and arch/quadrant on claim.	
D1517	space maintainer --fixed--bilateral, mandibular	2-12		No	One of (D1517, D1527) per 1 Lifetime Per patient. Indicate missing tooth numbers and arch/quadrant on claim.	
D1520	space maintainer-removable-unilateral	2-12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per patient. Indicate missing tooth numbers and arch/quadrant on claim.	
D1526	space maintainer --removable--bilateral, maxillary	2-12		No	One of (D1516, D1526) per 1 Lifetime Per patient. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	2-12		No	One of (D1517, D1527) per 1 Lifetime Per patient. Indicate missing tooth numbers and arch/quadrant on claim.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	2 - 20		No	Not covered within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	2 - 20		No	Not covered within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	2 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not covered within 6 months of initial placement.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-20		No		
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-20		No		

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Exhibit A Benefits Covered for
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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1575) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	

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Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty six months, unless there is recurrent decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Unusual anatomic tooth/ surface combinations may include, but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration. Cases may be considered with photographic evidence of extent of decay or restoration.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	1-11	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for
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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2150	Amalgam - two surfaces, primary or permanent	1-11	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	5 - 20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	1-11	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	1-11	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	1-11	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	
D2330	resin-based composite - one surface, anterior	5 - 20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	1-11	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	5 - 20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	1-11	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	
D2332	resin-based composite - three surfaces, anterior	5 - 20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1-11	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	5 - 20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	1-11	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Restoration of D-G, N-Q will be disallowed after age 6.	
D2390	resin-based composite crown, anterior	5 - 20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	1-11	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	5 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	1-11	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	5 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	1-11	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	5 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	1-11	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	5 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2740	crown - porcelain/ceramic	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2751	crown - porcelain fused to predominantly base metal	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2790	crown - full cast high noble metal	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	16-17	Teeth 3, 14, 19, 30	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	18 - 20	Teeth 2 - 15, 18 - 31	Yes	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Duplicated code due to variance in age limits, please read review next line item.	pre-operative x-ray(s)
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of initial placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 1 - 32	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. One of (D2710, D2712, D2720, D2721, D2722, D2750, D2780, D2781, D2782, D2783) per 60 Month(s) Per patient per tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth A - T	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-10	Teeth A - T	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	6 - 20	Teeth 1 - 32	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	0-11	Teeth C - H, M - R	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Restoration of D-G, N-Q will be disallowed after age 6.	
D2932	prefabricated resin crown	5 - 20	Teeth 1 - 32	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-11	Teeth C - H, M - R	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Restoration of D-G, N-Q will be disallowed after age 6.	
D2933	prefabricated stainless steel crown with resin window	5 - 20	Teeth 1 - 32	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-10	Teeth A - T	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2940	protective restoration	0-20	Teeth 1 - 32	No	Not reimbursable on primary teeth. No definitive restorative treatment billable for a minimum of 14 days after D2940.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2941	Interim therapeutic restoration - primary dentition	0-20	Teeth A - T	No	Only payable in conjunction with D1354 on same DOS - no definitive or restorative care will be paid on same tooth for a minimum of 6 months.	
D2950	core buildup, including any pins when required	6 - 20	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	6 - 20	Teeth 1 - 32	No	Maximum of 3 pins. Not reimbursable in conjunction with code D2950.	
D2952	cast post and core in addition to crown	6 - 20	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	Endodontic fill radiographs
D2954	prefabricated post and core in addition to crown	6 - 20	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	Endodontic fill radiographs

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Reimbursement includes local anesthesia.

In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

Complete root canal therapy includes, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No	One of (D3221) per 1 Lifetime Per patient per tooth. Not to be used by provider completing endodontic treatment.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 1 - 32, A - T	Yes	One of (D3222) per 1 Lifetime Per patient per tooth. Not to be used by provider completing endodontic treatment.	pre-operative x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-10	Teeth C - H, M - R	Yes	One of (D3230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-10	Teeth A, B, I - L, S, T	Yes	One of (D3240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6 - 20	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	11 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3331	treatment of root canal obstruction; non-surgical access	6 - 20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3346	retreatment of previous root canal therapy-anterior	6 - 20	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	11 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	5-12	Teeth 1 - 32	Yes	One of (D3351) per 1 Lifetime Per patient per tooth. Maximum of two visits per tooth (initial and final).	pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	5-12	Teeth 1 - 32	Yes	One of (D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	5-12	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	6 - 20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	11 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	6 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Three of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3430	retrograde filling - per root	6 - 20	Teeth 1 - 32	Yes	One of (D3430) per 1 Lifetime Per patient per tooth. Reimbursable only in addition to apicoectomy, maximum of three roots per tooth.	pre-operative x-ray(s)

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Exhibit A Benefits Covered for TN - TennCare Children

Reimbursement includes local anesthesia, suturing if needed, and routine post operative care.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A minimum of (4) teeth in the affected quadrant. Only for the correction of severe hyperplasia or hypertrophy associated with drug therapy or congenital defects.	Perio Charting, pre-op radiographs and narr of med necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. 1 to 3 teeth in the affected quadrant. Only for the correction of severe hyperplasia or hypertrophy associated with drug therapy or congenital defects.	Perio Charting, pre-op radiographs and narr of med necessity
D4341	periodontal scaling and root planing - four or more teeth per quadrant	14 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant	14 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant.	
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0-20		No		
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	14 - 20		No	One of (D4355) per 1 Lifetime Per patient. Not allowed within 12 months following D1110, D4341, or 4342.	

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A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments or relines during the six (6) month period following delivery and routine post delivery care.

BILLING AND REIMBURSEMENT FOR COMPLETE OR PARTIAL REMOVABLE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ON THE INSERTION/CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	18 - 20	Per Arch (01, UA)	Yes	One of (D5110) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	18 - 20	Per Arch (02, LA)	Yes	One of (D5120) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	8 - 20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	8 - 20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	0-20		No	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	0-20		No	One of (D52112, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284) per 60 Month(s) Per patient.	
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5286) per 60 Month(s) Per patient.	
D5511	repair broken complete denture base, mandibular	8 - 20		No	Not covered within 6 months of placement.	
D5512	repair broken complete denture base, maxillary	8 - 20		No	Not covered within 6 months of placement.	
D5520	replace missing or broken teeth - complete denture (each tooth)	8 - 20	Teeth 1 - 32	No	Not covered within 6 months of placement.	
D5611	repair resin partial denture base, mandibular	8 - 20		No	Not covered within 6 months of placement.	
D5612	repair resin partial denture base, maxillary	8 - 20		No	Not covered within 6 months of placement.	
D5621	repair cast partial framework, mandibular	8 - 20		No	Not covered within 6 months of placement.	
D5622	repair cast partial framework, maxillary	8 - 20		No	Not covered within 6 months of placement.	
D5630	repair or replace broken retentive/clasping materials per tooth	8 - 20	Teeth 1 - 32	No	Not covered within 6 months of placement.	
D5640	replace broken teeth-per tooth	8 - 20	Teeth 1 - 32	No	Not covered within 6 months of placement.	
D5650	add tooth to existing partial denture	8 - 20	Teeth 1 - 32	No	Not covered within 6 months of placement.	
D5660	add clasp to existing partial denture	8 - 20	Teeth 1 - 32	No	Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (chairside)	18 - 20		No	One of (D5730, D5750) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	18 - 20		No	One of (D5731, D5751) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	18 - 20		No	One of (D5740, D5760) per 36 Month(s) Per patient. Not covered within 6 months of placement.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5741	reline mandibular partial denture (chairside)	18 - 20		No	One of (D5741, D5761) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5750	reline complete maxillary denture (laboratory)	8 - 20		No	One of (D5730, D5750) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5751	reline complete mandibular denture (laboratory)	8 - 20		No	One of (D5731, D5751) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5760	reline maxillary partial denture (laboratory)	8 - 20		No	One of (D5740, D5760) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5761	reline mandibular partial denture (laboratory)	8 - 20		No	One of (D5741, D5761) per 36 Month(s) Per patient. Not covered within 6 months of placement.	

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Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-10	Teeth A, C, H, J, K, T	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-5	Teeth O, P	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-6	Teeth E, F, N, Q	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-7	Teeth D, G, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth B, I, L, M, R, S	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Includes cutting of gingiva and bone, removal of tooth structure and closure.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7220	removal of impacted tooth-soft tissue	14 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymtomatic tooth or tooth free from pathlogy is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	14 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymtomatic tooth or tooth free from pathlogy is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	14 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymtomatic tooth or tooth free from pathlogy is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	6 - 20	Teeth 1 - 32, 51 - 82	Yes	Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7260	oroantral fistula closure	0-20		Yes		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	6 - 20	Teeth 1 - 32	Yes	Includes splinting and/or stabilization.	narr. of med. necessity, post-op x-ray(s)
D7280	Surgical access of an unerupted tooth	12 - 20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	12 - 20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	0-20		Yes		Pathology report
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	18 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Not allowed with surgical extractions in the same quadrant.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	18 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Not allowed with surgical extractions in same quadrant.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	18 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in an edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	18 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7410	radical excision - lesion diameter up to 1.25cm	0-20		Yes		
D7411	excision of benign lesion greater than 1.25 cm	0-20		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7471	removal of exostosis - per site	18 - 20	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	18 - 20		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not allowed on same date as extraction.	narrative of medical necessity
D7961	buccal / labial frenectomy (frenulectomy)	11 - 20		Yes	The frenum may be excised when the tongue has limited mobility; for large diastmas(D7960 or D7963).; when the frenum interferes with a prosthetic appliance; or when it is etiology of periodontal tissue disease (D7960 or D7963).	narr. of med. necessity, pre-op x-ray(s)
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	The frenum may be excised when the tongue has limited mobility.	narr. of med. necessity, pre-op x-ray(s)
D7963	frenuloplasty	11 - 20		Yes	The frenum may be excised when the tongue has limited mobility; for large diastmas(D7960 or D7963).; when the frenum interferes with a prosthetic appliance; or when it is etiology of periodontal tissue disease (D7960 or D7963).	narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	18 - 20	Per Arch (01, 02, LA, UA)	Yes	One of (D7970) per 1 Lifetime Per patient per arch.	narrative of medical necessity
D7971	excision of pericoronal gingiva	6 - 20	Teeth 1 - 32	Yes	One of (D7971) per 1 Lifetime Per patient per tooth.	narrative of medical necessity

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Exhibit A Benefits Covered for
TN - TennCare Children

TennCare Members age 20 and under may qualify for orthodontic care under the program. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 1/2 years of age, treatment must be initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.

Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. The Member should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

Diagnostic study models (trimmed) with waxbites or the electronic equivalent through OrthoCAD, and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member; or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.

Provider must submit a ‘provider signed' ortho readiness necessity form and completed MSA form with authorization request in order for the case to be reviewed for medical necessity. Failure to submit these forms will result in a denial of the service.

If a comprehensive ortho case is denied, the prior authorization will be returned to the provider indicating that DentaQuest will not cover the orthodontic treatment. However, an approved authorization will be issued for the pre-orthodontic visit (code D8660) which includes radiographs, treatment plan, records, and diagnostic models. This authorization will be automatically generated for any case denied for full treatment; however, the provider is still responsible for filing a claim for D8660 for the date of service of the pre-treatment visit.

General Billing Information for Orthodontics

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth (banding date). The Member must be eligible on this date of service.

If a Member becomes ineligible during treatment and before full payment is made, it is the Member's responsibility to pay the balance for any remaining treatment. The provider should notify the Member of this requirement prior to beginning treatment.

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

Electronically file, fax or mail a copy of our Authorization Determination letter with the date of service (banding date) filled in. Initial payment for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, and initial banding. Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. After banding, Providers then must submit claims for periodic orthodontic treatment visits (code D8670) no more frequently than one per 30 days. The Member must be eligible on the date of the visit.

The maximum case payment for orthodontic treatment will be 1 initial payment (code D8080), 23 periodic orthodontic treatment visits (code D8670), and debanding and retention (code D8680).

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Additional periodic orthodontic treatment visits beyond 23 will be the provider's financial responsibility and not the Member's. Members may not be billed for broken, repaired or replacement of brackets or wires.
After the banding (D8080) and 23 adjustments (D8670) have been completed, the provider is eligible to bill for D8680, debanding and retention. No prior authorization is necessary to bill for this code. If member has completed treatment in less than 23 monthly visits, please include a narrative stating such.

The Member must be eligible in order for payments to be made. Whenever the member becomes ineligible, the Member is responsible for payment during that time period.

If a comprehensive case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. In order to receive payment of records for cases that are denied, a claim must be submitted on an ADA form including code D8660. The date of service will be the date the treatment plan, radiographs and/or photos, records and diagnostic models were performed by the provider.

Please notify DentaQuest should the Member discontinue treatment for any reason Continuation of Treatment
DentaQuest requires the following information for possible payment of continuation of care cases:

Original banding date
A detailed paid-to-date history showing dollar amounts for initial banding and periodic orthodontic treatment fees.
A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fee.
If the Member started treatment under commercial insurance or fee for service, we must receive the original banding date and a detailed payment history. It is the provider's and Member's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.
Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	12 - 20		Yes	One of (D8080) per 1 Lifetime Per patient. Includes pre-orthodontic treatment visit, x-rays, treatment plan, diagnostic models, initial banding, debanding, one set of retainers and a maximum of 23 months of adjustments. Please submit provider signed ortho readiness necessity form, completed MSA form, and OrthoCAD submission form if applicable.	Study Models, pan or peri xrays, narr/treatment plan
D8670	periodic orthodontic treatment visit	12 - 20		Yes	Twenty-Three of (D8670) per 1 Lifetime Per patient. One of (D8670) per 1 Calendar month(s) Per patient. Please submit orthodontic continuation of care submission form.	Study model or OrthoCad
D8680	orthodontic retention (removal of appliances)	12 - 20		No	1 of (D8680) per lifetime per patient after completed orthodontic treatment.	
D8703	Replacement of lost or broken retainer - maxillary	0-20		Yes		

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Exhibit A Benefits Covered for
TN - TennCare Children

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8704	Replacement of lost or broken retainer - mandibular	0-20		Yes		

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Reimbursement includes local anesthesia.

General Anesthesia and IV Sedation will be reviewed on a case by case basis for medical necessity.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	One of (D9110) per 1 Day(s) Per Provider OR Location. Not allowed with any other services other than x-rays and emergency exams.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9239, D9243, or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Five of (D9223) per 1 Day(s) Per patient. Not allowed in conjunction with D9230, D9243, or D9248.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	One of (D9223, D9243, D9248) per 1 Day(s) Per patient. One (1) Per Date of Service. Narrative of medical necessity kept in patient record.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed in conjunction with D9222, D9223, D9230, or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Five of (D9243) per 1 Day(s) Per patient. Not allowed in conjunction with D9223, D9230, or D9248.	narrative of medical necessity
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes	One of (D9223, D9230, D9243) per 1 Day(s) Per patient.	narrative of medical necessity

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