DentaQuest USA Insurance Company, Inc.

Office Reference Manual

Humana Healthy Horizons® in Louisiana
Aetna Better Health of Louisiana
Healthy Blue of Louisiana

Please refer to your Participation Agreement for plans in which you contract.

DentaQuest
11100 W. Liberty Drive
Milwaukee, WI 53224

www.DentaQuest.com/Louisiana

125401LA1122

DentaQuest of Louisiana, Inc.
Address and Telephone Numbers

DentaQuest Corporate Office Address:
11100 W. Liberty Drive
Milwaukee, WI 53224

Louisiana Provider Services:
- **DentaQuest General Provider Services Queue:**
  1-800-508-6785

Fax numbers:
- **Claims to be processed:**
  1-262-834-3589

Email Addresses:
- **Claims Questions:**
  denclaims@DentaQuest.com

- **Eligibility or Benefit Questions:**
  denelig.benefits@DentaQuest.com

Fraud Hotline:
- **1-800-237-9139**

Review Requests should be sent to:
DentaQuest – UM Department
11100 W. Liberty Drive
Milwaukee, WI 53224

Credentialing:
11100 W. Liberty Drive
Milwaukee, WI 53224
Fax: 1-262-241-4077

Credentialing Hotline:
1-800-233-1468

General TTY Number:
1-800-684-5505

Claims should be sent to:
DentaQuest - Claims
11100 W. Liberty Drive
Milwaukee, WI 53224

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 USA Insurance Company, Inc.

11100 W. Liberty Drive
Milwaukee, WI 53224

Short Procedure Unit (SPU) for review of Operating Room (OR) cases:
DentaQuest - SPU Department
11100 W. Liberty Drive
Milwaukee, WI 53224
Fax line: 1-262-834-3575

Louisiana Member Services:

- **DentaQuest General Member Services Queue:**
  1-800-964-7811

- **Healthy Blue of Louisiana:**
  1-844-834-9835

- **Aetna of Louisiana:**
  1-844-234-9834

- **Humana Healthy Horizons in Louisiana:**
  1-800-448-3810

DentaQuest of Louisiana, Inc.

The Louisiana Patient's Bill of Rights and Responsibilities

SUMMARY OF THE LOUISIANA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Louisiana law requires that your health care provider or healthcare facility recognizes your rights while you are receiving dental care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of you the patient. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing dental services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the dental care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for dental care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to dental treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency dental condition that will deteriorate from failure to receive treatment.
- A patient has the right to know if dental treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Louisiana law, through the grievance process of the dental care provider or dental care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to his or her dental care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the dental care provider.
- A patient is responsible for reporting to his or her dental care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by his or her dental care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the dental care provider or dental care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the dental care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her dental care are fulfilled as promptly as possible.
- A patient is responsible for following dental care facility rules and regulations affecting patient conduct.

DentaQuest of Louisiana, Inc. ("DentaQuest")

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DENTAQUEST.

3. File an appeal or complaint pursuant to the procedures of Plan/DENTAQUEST.

4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by Plan/DENTAQUEST.

6. Notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

7. Be informed of the status of their credentialing or recredentialing application, upon request.

* * *

DENTAQUEST shall disseminate bulletins as needed to incorporate any needed changes to this ORM.

DENTAQUEST makes every effort to maintain accurate information in this manual; however DentaQuest will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

Office Reference Manual
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1.00 Introduction

The information contained in this Provider Office Reference Manual is intended as a resource for you and your staff. It lists DentaQuest's standard administrative guidelines for claims processing as well as information regarding DentaQuest's standard policies. In all cases, specific group contract provisions, limitations and exclusions take precedence.

The introductory pages provide general information about DentaQuest's policies. The remaining pages are organized according to the most current edition of the Current Dental Terminology (CDT), published by the American Dental Association (ADA). For complete code descriptions, we strongly encourage you to purchase the most recent edition of the official CDT manual from the ADA by calling 1-800-947-4746 or visiting www.ada.org. The presence of a code in the CDT does not automatically mean that it is a covered benefit.

NOTE: DentaQuest reserves the right to add, delete or change the policies and procedures described in this reference guide at any time.

2.00 General Definitions

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

Adverse Determination: a utilization review decision by the Plan, or a health care provider acting on behalf of the Plan that:

a) decides a proposed or delivered health care service which would otherwise be covered under this Agreement is not, or was not medically necessary, appropriate, or efficient; and
b) may result in non-coverage of the health care service.
Adverse determination does not include a decision concerning a subscriber's status as a member.

Agreement: refers to the Account Dental Service Agreement, with the Subscriber Certificate(s), Schedule(s) of Benefits, Group Application, Enrollment Form, and any applicable rider(s), Endorsements, and Supplemental Agreements, represent the complete and integrated Agreement between the parties.

Appeal: a protest filed by a Covered Individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a Covered Individual.

Appeal Decision: a final determination by the Plan that arises from an appeal filed with the Plan under its appeal process regarding a coverage decision concerning a Covered Individual.

Balance Billing: When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. **An in-network provider may not balance bill for covered services.**

Complaint: An oral or written expression of dissatisfaction with the Utilization Review Agent (URA), concerning the URA's process in conducting a utilization review.

Contracting Dentist: a licensed dentist who has entered into an agreement with the Plan to furnish services to its Covered Individuals.

Covered Service: a list of dental procedures for which DentaQuest will reimburse providers. Covered Services are plan specific.

Date of Service: The actual date that the service was completed. With multi-stage procedures, the date of service is the final completion date (the insertion date of a crown, for example).

DentaQuest Service Area: State of Louisiana.

Effective Date: the date, as shown on the Plan's records, on which the subscriber's coverage begins under this Agreement or an amendment to it.

Emergency Medical Condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B). Emergency dental care includes treatment to relieve acute pain or control dental condition that requires immediate care to prevent permanent harm.

Exchange: The Small Business Health Options Program established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the ACA, codified as 42 U.S.C. § 18041(c).

Fee Schedule: the payment amount for the services that DQ has agreed to provide to Participating and Non-participating Dentists under their contract.

Filing date: the earlier of a.) five (5) days after the date of mailing; or b.) the date of receipt.

Grievance: a protest filed by a Covered Individual, a Covered Individual's Representative, or a health care provider acting on behalf of a Covered Individual, with the Plan through the Plan's internal grievance process regarding an adverse determination concerning the Covered Individual.

Grievance Decision: a final determination by the Plan that arises from a grievance filed with the Plan under its internal grievance process regarding an adverse determination concerning a Covered Individual.

Medically Necessary: means those Covered Services provided by a dentist, physician, or other licensed practitioner of the healing arts within the scope of their practice under State law to prevent disease, disability, and other adverse health conditions or their progression, or prolong life. In order to be Medically Necessary, the Plan or its designee in its judgment will determine if the service or supply for medical illness or injury is a Covered Service and which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of the dental and medical practice in the community.

Member: means any individual who is eligible to receive Covered Services pursuant to a Contract.

Non-Participating Dentist: a licensed dentist who has not entered into an agreement with the Plan to furnish services to its Covered Individuals.

Participating Provider: a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members

Plan Certificate: the document that outlines the benefits available to Members.

Provider: the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

Provider Dentist: a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

Schedule of Benefits: the part of this Agreement which outlines the specific coverage in effect as well as the amount, if any, that Covered Individuals may be responsible for paying towards their dental care.

The Plan: refers to DentaQuest of Louisiana, Inc.

Utilization Review: a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

3.00 Patient Eligibility Verification Procedures

3.01 Plan Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

3.02 Member Identification Card

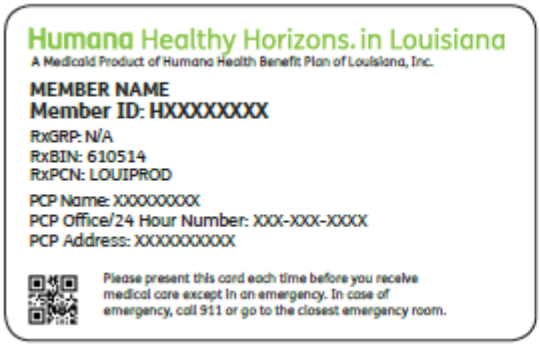
Members will receive a Plan ID Card. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Sample of the [Health Plan] I.D. Card:

[Insert Sample]

Sample of the Humana I.D. Card:



Sample of [Health Plan] I.D. Card:

[Insert Sample]

DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a Member lose eligibility. Therefore, an identification card in itself does not guarantee that a person is currently enrolled in the health plan.

3.03 DentaQuest's Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.DentaQuest.com/Louisiana. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Provider Services Department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Services Representative.

Access to eligibility information via the Internet:
DentaQuest's provider portal currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility online by entering the Member's date of birth, the expected date of service, and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply go to the website at www.DentaQuest.com/Louisiana. Once you have entered the website, click the link called "Login." 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. If you have not received instructions on how to complete Provider Self Registration contact DentaQuest's Provider Services Department at 1-800-508-6785. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check up to 30 patients at a time 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 Provider Services Department at 1-800-508-6785 and press 2 for eligibility. 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 Provider Services Representative to answer any additional questions, e.g., Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid, CHIP or Medicare Member by entering your six-digit DentaQuest location number, the Member's recipient identification number, and an expected date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Provider Services Representative.

Directions for using DentaQuest's IVR to verify eligibility:

1. Call DentaQuest Provider Services Department.
2. After the greeting, stay on the line for English or press 1 for
3. Spanish. 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**? 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, or get fax confirmation of your call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 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 Provider Services Department at 1-800-508-6785. They will be able to assist you in utilizing either system.

4.00 Participating Hospitals

Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office. To receive the most current list of MCE Healthcare participating hospitals, please contact each MCE at the numbers below:

Humana : <Insert phone number>
Healthy Blue: <Insert phone number>
Aetna Better Health: <Insert phone number>

Please refer to section 16.05, Criteria for Review of Operating Room (OR) cases, of this ORM for information on Operating Room (OR) criteria.

5.00 Payment for Non-covered Services

Participating Providers shall hold Members, DentaQuest, Plan, and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider 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, Plan, and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.

A recommended Member Consent Form can be found on the DentaQuest Provider Web Portal.

6.00 Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data

For each plan that DentaQuest administers, the plans may require review of certain procedures to ensure that procedures meet the requirements of federal and state laws and regulations and medical necessity criteria. DentaQuest performs the review using one of two processes – "prior authorization" or "prepayment review."

- "Prior Authorization" requires that the provider obtain permission to perform the procedure prior to performing the service. "Prior Authorization" requires specific documentation to establish medical necessity or justification for the procedure.

- "Prepayment Review" is the review of claims prior to determination and payment. "Prepayment Review" requires documentation to establish medical necessity or justification for the procedure. For procedures that require "Prepayment Review," providers may opt to submit a "Prior Authorization" request prior to performing the procedure. If DentaQuest approves the "Prior Authorization" request, it will satisfy the "Prepayment Review" process.

The Exhibits for each plan indicate which procedures require Review, which type of Review, and the documentation that the provider will need to submit to support his or her request. Utilization management decision making is based on appropriate care and service, and does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization. DentaQuest does not make decisions about hiring, promoting or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits.

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

- Electronic claims via DentaQuest's website www.DentaQuest.com/Louisiana.
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

DentaQuest utilizes claims submissions and information to collect encounter data.

6.01 Electronic Attachments

DentaQuest accepts dental radiographs electronically via FastAttach™ for review requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (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 EOBs. FastAttach is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments 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 FastAttach through Vyne Dental, go to FastAttach® - Vyne Dental or call NEA at:
1-800-782-5150.

6.02 Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit FastAttach® - Vyne Dental and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are five or more radiographs submitted at one time. If five or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member's name, identification number and office name to ensure proper handling.

6.03 Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Internet Website

Participating Providers may submit Prior Authorizations or Claims including claims requiring Prepayment Review directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Prior Authorizations or 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 prior authorizations or claims via the website, simply log on to www.DentaQuest.com/Louisiana. 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. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Services Department at 1-800-508-6785. Once logged in, select "Claims/Prior Authorizations" and then either "Dental Pre-Auth Entry" or "Dental Claim Entry" depending if you are submitting a Prior authorization or a claim.

The Dentist Portal also allows you to attach electronic files (such as X-rays in jpeg format, reports and charts) to the request.

If you have questions on submitting prior authorizations or claims or accessing the website, please contact our Systems Operations Department at 1-888-560-8135 or via email at: EDITeam@DentaQuest.com.

6.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-363-3361), Tesia (1-800-724-7240), EDI Health Group (1-800-576-6412), Secure EDI (1-877-466-9656) and Mercury Data Exchange (1-540-777-4260), 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.

6.05 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@dentaquest.com to inquire about this option for electronic claim submission.

6.06 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 Dental.

- Providers must register for the appropriate NPI classification at the following website https://npiregistry.cms.hhs.gov/search and provide this information to DentaQuest Dental 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 Dental 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 NPIs. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

- If you are presently submitting claims to DentaQuest Dental through a clearinghouse or through a direct integration you need to review your integration to assure that it complies with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

6.07 Paper Claim Submission

- Claims must be submitted on ADA-approved claim forms (2006 or newer ADA claim form) 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. 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 National Provider Identifier (NPI). 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 two 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.

Claims should be mailed to the following address:

DentaQuest – Claims
11100 W. Liberty Drive
Milwaukee, WI 53224

6.08 Coordination of Benefits (COB)

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.

6.09 Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing," the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

6.10 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 Provider Services Department 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.

6.11 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 that can be found on the website www.DentaQuest.com/Louisiana.
- 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 – 1-262-241-4077

Via Mail – DentaQuest USA Insurance Company, Inc.
11100 W. Liberty Drive
Milwaukee, WI 53224
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 Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.DentaQuest.com/Louisiana.
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.

6.12 Provider Recognition in State Medicaid Program

DentaQuest is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the HIP and that the provider's submission of encounter data is accepted by DentaQuest and Louisiana MMIS and/or the state's encounter data warehouse.

7.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures also compliant with the Privacy Standards. DentaQuest is compliant with Administrative Simplification and Security Standards. One aspect of our compliance plan is to work cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, provider contracts reflect the appropriate HIPAA compliance language.

The 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 and Security Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards recognized by the American Dental Association's Current Dental Terminology (CDT) codes. Effective the date of this manual,

DentaQuest will require providers to submit all claims with the current CDT codes. 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 Provider Services Department at 1-800-508-6785 or via email at denelig.benefits@DentaQuest.com.

7.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.DentaQuest.com/Louisiana. 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. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right-hand side of the screen).

8.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series)

DentaQuest adheres to State, Federal, and Plan requirements related to processing inquiries, complaints, and grievances. Enrollees have the right to request continuation of benefits while utilizing the grievance system. Unless otherwise required by Agency and Plan, DentaQuest's processes such inquiries, complaints, grievances, and appeals are consistent with the following:

A. Definitions:

Inquiry: An inquiry is the first contact with the Plan (verbal or written) expressing dissatisfaction from the Member, an attorney on behalf of a Member, or a government agency.

Complaint: A complaint is any oral or written expression of dissatisfaction by a Member submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the member's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the member's rights.

Appeal – A formal request from a member to seek a review of an action taken by the Health Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an action.

B. Complaints/Grievance Staff:

DentaQuest's Complaints/Grievance Coordinator receives Member and Provider inquiries, complaints, grievances, and appeals. DentaQuest's Complaints/Grievance Coordinator has office hours from Monday through Friday, 8:00 a.m. to 5:30 p.m. The Coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals (i.e. Plan, Member, and Provider as applicable) are notified in writing of

the resolution. The complaint is closed and maintained on file for tracking and trending purposes.

The Complaints/Grievances Coordinator receives Member and Provider grievances. The Coordinator requests appropriate documentation and forwards the documentation to the dental consultant for review and determination. The decision to uphold or overturn the initial decision is communicated to the appropriate individuals.

Contact information for each plan is located in the table in Section D below.

C. Provider Appeals:

Contracted providers have a right to file an appeal for denied claims (which include prepayment review process), prior authorizations, and/or referral determinations. This can be done by submitting a request for appeal in writing with a narrative and supporting documentation to the DentaQuest Provider Appeals Coordinator via mail or fax. All appeals should be sent to the attention of DentaQuest-Provider Appeals, 11100 W. Liberty Drive, Milwaukee, WI 53224. Provider Appeals Fax line: 1-262-834-3452. Providers can also call 1-877-468-5581 from Monday through Friday, 8:00 a.m. to 5:30 p.m. to file their complaint and/or appeals.

D. Member Complaints/Grievances/Appeals:

Members can file their complaints, grievances and/or Appeals to:

Member's Plan	Telephone	Mail
Humana Healthy Horizons in Louisiana	1-800-448-3810	P.O. Box 14546 Lexington, KY 40512-4546

E. Second Level Appeals: Members who are not happy with the decision of their first appeal may request the appeal be reviewed a second time by an appeal committee. Second level appeals must be submitted to Louisiana Department of Health and Hospitals in writing at:

Louisiana Department of Health and Hospitals
Division of Administration – Administrative Law Judge Division
628 N. 4th Street
Baton Rouge, LA 70802

F. Policy and Procedures:

Copies of DentaQuest's policies and procedures can be requested by contacting Provider Services at 1-800-508-6785.

G. Independent Review DentaQuest on behalf of Humana Healthy Horizons®.

The Independent Review process was established by LA-RS 46:460.81, et seq. to resolve claims disputes when a provider believes a managed care organization (MCO) has partially or totally denied claims incorrectly. The rendering provider must submit an Independent Reconsideration Review (IRR) to DentaQuest on behalf of Humana Healthy Horizons before requesting an independent Review from LDH. If DentaQuest on behalf of Humana Healthy Horizons upholds the adverse determination, then provider has 60 calendar days to request an independent review from the Health Plan Management Department at LDH. Please note, post-payment reviews conducted by the Special Investigations Unit (SIU) do not meet criteria for Independent Review and are exempt from this process except for mental health rehabilitation (MHR) service providers. MHR service providers have the right to an Independent Review for recoupments related to an adverse determination resulting from fraud waste or abuse.

Subject to review by LDH, providers may aggregate multiple adverse determinations involving DentaQuest on behalf of Humana Healthy Horizons when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. If a provider elects to aggregate its claims, the independent reviewer may, upon request, allow for up to an additional 30 days to provide relevant information related to the independent review requests.

Independent review is a two-step process.

Step One:
Submit a request for independent review reconsideration (IRR) to DentaQuest on behalf of Humana Healthy Horizons within 180 days from one of the following:

1. Date on which the MCO transmitted remittance advice or notice of claim denial.
2. 60 days from the date the claim was submitted to the MCO if the provider receives no notice from the MCO either partially or totally denying the claim.
3. Date on which the MCO recoups payment for a previously paid claim.

DentaQuest on behalf of Humana Healthy Horizons will acknowledge in writing receipt of the IRR request within five calendar days of receipt. A final decision of the request will be rendered within 45 calendar days, unless another time frame has been agreed upon in writing.

Step Two:
If DentaQuest on behalf of Humana Healthy Horizons upholds the adverse determination or does not respond to the IRR request within the allowed 45 calendar days, the provider may then submit the Independent Review to LDH. LDH must receive the IRR request within:

1. 60 days of the date the provider received the MCO decision of the IRR request: or
2. If the provider does not receive a decision within the 45-calendar day time frame, the provider has 60 days from the date the IRR was submitted to DentaQuest on behalf of Humana Healthy Horizons to request an independent review from LDH.

Providers can expect the following after requesting an independent review:

1. LDH will determine eligibility for review within 10 business days.
2. The independent reviewer will contact providers within 14 calendar days to request all information and documentation regarding the disputed claim or claims.
3. All information and documentation must be received within 30 calendar days of the independent reviewer's request. The independent reviewer will not consider any information or documentation not received within the 30-day time frame.
4. The independent reviewer will provide a resolution within 60 calendar days.
5. The independent reviewer may request in writing an extension of time from LDH to resolve the dispute. If an extension of time is granted by LDH, then the independent reviewer shall provide notice of the extension time to both the provider and Humana Healthy Horizons.
6. If the independent reviewer renders a decision requiring DentaQuest on behalf of Humana Healthy Horizons to pay any claims or portion of the claims, then Humana Healthy Horizons will send the payment within 20 days of the reviewer's decision.
7. Within 10 days of the reviewer's decision the provider shall reimburse DentaQuest on behalf of Humana Healthy Horizons for the fee associated with conducting an independent review when Humana Healthy Horizons' appeal decision is upheld.
8. Within 60 days of the independent reviewer's decision, either the provider or Humana Healthy Horizons may file suit in any court having jurisdiction to review the independent reviewer's decision and to recover any funds awarded by the independent reviewer to the other party. Any claim concerning an independent reviewer's decision that is not brought within 60 days of the decision shall be barred indefinitely.

Note: Per House Bill No. 492 Act No. 349, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review. There is a $750 fee associated with an IRR request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. If the reviewer finds in favor of the MCO, the provider is responsible for paying the fee.

IRR forms:

Humana: Independent Review Request Form – Humana (found in the resource section of the provider portal)

LDH: https://ldh.force.com/Reporting/s/independentreview

9.00 Utilization Management Program (Policies 500 Series)

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 governments. 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 copayment, 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.

9.01 Community Practice Patterns

To do this, 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 health care 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 individual dentist 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.

9.02 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
- Treatment cost effectiveness.

9.03 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.

9.04 Fraud and Abuse (Policies 700 Series)

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 herself 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.

Provider Fraud: 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 may be referred to the appropriate state regulatory agency.

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.

10.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes but is not limited to:

- Provider credentialing and recredentialing
- Member satisfaction surveys
- Provider satisfaction surveys
- Random Chart Audits
- Complaint Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Initial Site Reviews and Dental Record Reviews

- Quarterly Quality Indicator tracking (e.g., complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Services Department at 1-800-508-6785 or via email at: denelig.benefits@DentaQuest.com.

11.00 Credentialing (Policies 300 Series)

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to NCQA guidelines and plan requirements.

DentaQuest, in conjunction with the Plan, has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, 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 of the Plan.

Nothing in this Credentialing Plan limits DentaQuest's sole discretion to accept and 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.

The Plan has the final decision-making power regarding network participation. DentaQuest will notify the Plan of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendations (Policy 300.017)
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.

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 36 months.
Note: The aforementioned policies are available upon request by contacting DentaQuest's Provider Services Department at 1(800) 508-6785 or via email at denelig.benefits@DentaQuest.com.

11.01 Termination

DentaQuest at any time may terminate a provider for cause or at will for no cause.

If a provider wishes to drop out of a plan, he or she must give DQ 30 days written notice prior to discontinuing seeing members. Additionally, the provider must complete any procedures that are in progress or assist DQ in transferring members to another DQ provider.

12.00 The Patient Record

A. **Organization**

1. The record must have areas for documentation of the following information:

   a. Registration data including a complete health history.
   b. Medical alert predominantly displayed inside chart jacket.
   c. Initial examination data.
   d. Radiographs.
   e. Periodontal and Occlusal status.
   f. Treatment plan/Alternative treatment plan.
   g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
   h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.

   a. Health history.
   b. Medical alert.
   c. Examination/Recall data.
   d. Periodontal status.
   e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient, (i.e., patient name and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

B. **Content — The patient record must contain the following:**

1. Adequate documentation of registration information which requires entry of these items:

   a. Patient's first and last name.
   b. Date of birth.
   c. Sex.
   d. Address.
   e. Telephone number.
   f. Name and telephone number of the person to contact in case of emergency.
   g. Information regarding the primary language of the member.
   h. Information related to the member's needs for translation services.

2. An adequate health history that requires documentation of these items:

   a. Current medical treatment.
   b. Significant past illnesses.
   c. Current medications.
   d. Drug allergies.
   e. Hematologic disorders.

f. Cardiovascular disorders.
g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.
n. Summary of significant surgical procedures.
o. Treating provider's signature and/or initials must be documented on each date of service.
p. Treating provider's signature and/or initials must contain the profession designation (e.g., DDS, DMD, RDH, CDA).

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

   a. Significant changes in health status.
   b. Current medical treatment.
   c. Current medications.
   d. Dental problems/concerns.
   e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:

   a. Health problems which contraindicate certain types of dental treatment.
   b. Health problems that require precautions or pre-medication prior to dental treatment.
   c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   d. Drug sensitivities.
   e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Occlusal classification.
   f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Dentition charting.

7. Radiographs which are:

   a. Identified by patient name.
   b. Dated.

c. Designated by patient's left and right side.
d. Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

   a. Procedure.
   b. Localization (area of mouth, tooth number, surface).

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure.
    b. Description of service, procedure, and observation. Documentation in treatment must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth basis for a per tooth code, on a quadrant basis for a quadrant code, and on a per-arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation. (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination.
    b. Treatment plan.
    c. Treatment status.

C. **Compliance**

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

13.00 Patient Recall System Requirements

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 health plan 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 teeth healthy."

- "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 Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

- 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 supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

B. **Office Compliance Verification Procedures**

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- Emergency care must be available 24 hours a day, seven days a week.
- Urgent care must be available within one day.
- Sick care must be available within one week.
- Routine care must be available within one month.

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

14.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A. **Radiographic Examination of the New Patient**

1. Child – Primary Dentition

   The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – Transitional Dentition

   The Panel recommends an individualized Periapical/Occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

4. Adult – Dentulous

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

5. Adult – Edentulous

   The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

B. **Radiographic Examination of the Recall Patient**

1. Patients with clinical caries or other high-risk factors for caries

   a. Child – Primary and Transitional Dentition

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

   c. Adult – Dentulous

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for adults with clinical caries or who are at increased risk for the development of caries.

   d. Adult – Edentulous

      The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose, and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high-risk factors for caries

   a. Child – Primary Dentition

      The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

   b. Adolescent

      The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

   c. Adult – Dentulous

      The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent, and Dentulous Adult

   The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease (except nonspecific gingivitis).

4. Growth and Development Assessment

   a. Child – Primary Dentition

      The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

   b. Child – Transitional Dentition

      The Panel recommends an individualized periapical/occlusal series OR a panoramic radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

   c. Adolescent

      The Panel recommends that for the adolescent (age 16-19 years) recall patient, a single set of periapicals of the wisdom teeth OR a panoramic radiograph.

   d. Adult

      The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

14.01 Criteria for Radiographs

American Dental Association (ADA) and American Association of Pediatric Dentists (AAPD) guidelines recommend that the number and type of radiographs should be based on the risk level of the patient and whether or not the provider can visualize the entire tooth. The following link describes current ADA and AAPD guidelines for radiographs.

https://www.aapd.org/media/Policies_Guidelines/BP_Radiographs.pdf

Panoramic Radiograph vs. Complete Series (FMX)
It is a fairly common occurrence for providers to perform a panoramic film instead of a full mouth series. Panoramic films alone are not considered sufficient for the diagnosis of decay and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. In cases where a provider is combining a panoramic film and bitewings, the benefit will equal that of a full mouth series. This down-paying of services aligns with AHCA's guidelines and the concept of medical necessity (reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide) and, according to the ADA, is a result of requests from the dental community. See section of Reimbursement of Services Rendered below. This section details AHCA's guidance on reimbursement of services.

15.00 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual (ORM) are based around procedure codes as defined in the American Dental Association's Code Manuals and AHCA guidance which can be found at https://www.ada.org/publications/cdt. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as *guidelines* for review and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment to and belief in providing quality care to Members, and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review; this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

For all procedures, every Provider in the DentaQuest program is subject to random

chart audits. Providers are required to comply with any request for records.
These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse 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.

15.01 Criteria for Dental Extractions

Not all procedures require review.

Documentation needed for review procedure:

- Appropriate radiographs showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals, or panorex.
- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e., third molars) or teeth exhibiting no overt clinical pathology (except for orthodontics) is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

1. GP, pedo, or ortho determines patient may need 3rd molars extracted - no referral is necessary.
   a. Can refer patient directly to DQ oral surgeon
   b. Provider or member can call DQ - 1-888-468-5509. DQ will assist member in finding an OS
2. Oral Surgeon - Submission of treatment for approval

a. Non-emergency
    i. Pre-payment review – perform treatment and submit documentation with claim – no guarantee provider will get paid for service – procedure must meet medical necessity guidelines for DQ to pay.
    ii. Prior authorization – submit documentation prior to performing treatment. If DQ approves, provider is guaranteed payment as long as patient is eligible on date of service.
b. Emergency (treatment necessary within 24 hours) – if want prior approval - fax request to 1-262-387-3736. Requests must still include documentation when required

3. Documentation of medical necessity for oral surgery - evidence of diagnosed pathology or demonstrable need (including ortho), rather than anticipated future pathology.
    a. Pathology
        i. Provider must submit narrative and X-rays or photos describing pathology
        ii. Each tooth must show pathology
        iii. Symptomology or impactions without pathology may not be enough
    b. Demonstrable need
        i. Narrative describing need
        ii. Supporting documentation (e.g., X-rays, photos, hospital admissions, etc.)
    c. Extractions in conjunction with approved orthodontic treatment
        i. Provider must submit request for extractions from orthodontist
        ii. Needs to be an approved orthodontic case
        iii. To expedite process, provider may also want to submit orthodontic approval

4. General Approval vs. Denial Guidelines
    a. Probable Approval
        i. Pathology =
            1. Non-restorable decay
            2. Tooth erupting on an angle and impinging on 2nd molars
            3. Recurrent Pericoronitis
            4. Dentigerous Cyst or other growth
            5. Internal or External Root Resorption
            6. 3rd molar has over-erupted due to lack of opposing tooth contact
        ii. Demonstrable need =
            1. **In conjunction with approved orthodontics** where orthodontist requests the 3rd molars be removed to guarantee the success of the orthodontic case (provide referral from ortho and prior auth approval of ortho if possible)
            2. **Pain with no pathology** – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need
    b. Probable Denial
        i. Impaction or Symptomology =
            1. Impaction with no other pathology
            2. Pain or discomfort with unknown pathology
        ii. Other 3rd molars have pathology (if one, two, or three teeth show pathology, DQ will not automatically approve the extraction of the remaining non-pathologic teeth)

5. Denials
    a. If administrative denial (e.g., lack of documentation) – Resubmit according to deficiencies noted in EOB
    b. If clinical denial:
        i. Resubmit with documentation showing additional clinical evidence for extraction

ii. Advise member service is not covered
    1. Member can appeal following appeal process in member handbook
    2. Provider and member may work out an out-of-pocket arrangement

The removal of primary teeth whose exfoliation is imminent does not meet criteria.

Alveoloplasty (code D7310) is a covered service only when the procedure is done in conjunction with four or more extractions in the same quadrant. Alveoloplasty will not be covered when done in conjunction with surgical extractions.

16.05 Criteria for Review of Operating Room (OR) Cases

All OR cases MUST be reviewed.

Provider must submit the following documents for review via fax to MCE directly for review of OR cases:

- Copy of the patient's dental record including health history, charting of the teeth, and existing oral conditions.
- Diagnostic radiographs or caries-detecting intra-oral photographs†.
- Copy of treatment plan. A completed ADA claim form submitted for review 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 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 or approved for treatment.

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

The provider is responsible for choosing facilities/providers from Member's MCO panel, obtaining all necessary approvals, 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 review request but would assume that this information would be documented in the patient record.

Criteria

In most cases, OR will be approved (for procedures covered by health plan) if the following is (are) involved:

- 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 not medically appropriate.*

- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.*

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

* The medical condition should be verified by a Primary Care Provider (PCP) narrative, which is submitted with the review request.

16.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for review of procedure:

- Treatment plan (authorized if necessary).

- Narrative describing medical necessity for general anesthesia or IV sedation.
- Treatment rendered under emergency conditions, when review is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

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

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.

- Surgical root recovery from maxillary antrum.

- Surgical exposure of impacted or 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, cognitive disability, including Down syndrome) which would render patient non-compliant.

- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

- Patients 3 years old and younger with extensive procedures to be performed.

17.00 Cultural Competency Program

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as health care services. Services to Members are delivered in a manner sensitive to the Member's cultural background and his/her religious beliefs, values, and traditions. It is the policy of DentaQuest to provide Medicare, Medicaid, Commercial, and DentaQuest employee information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or physical or mental disabilities, or those with issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent services to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its Members and DentaQuest employees and report appropriate occurrences to the Complaint and Grievance Department or the Human Resources Department.

DentaQuest ensures that its members and staff are trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of Members and all DentaQuest employees.

DentaQuest supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet Members' cultural and linguistic needs.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Provider Services Department at 1-800-508-6785 or via email at: denelig.benefits@DentaQuestusa.com.

18.00 Reimbursement of Services Rendered

Reimbursement will only occur for services that are medically necessary and do not duplicate another provider's service. "Medically necessary" is defined as services that meet the following conditions:

- necessary to protect life, prevent significant illness or significant disability or alleviate severe pain
- individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide

In addition, the services must meet the following criteria:

- The services cannot be experimental or investigational; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

APPENDIX A - Attachments

Additional Resources

The following DentaQuest provider forms can be accessed through our portal. To view copies please visit our website at www.DentaQuest.com/Louisiana. Once you have entered the website, click ”Login” located at the top right corner. You will then be able to log in using your User ID and Password. Once logged in, select the link “Related Documents” to access the following resources:

- Acknowledgment of Disclosure & Acceptance of Member Financial Responsibility Consent Form
- Authorization for Dental Treatment
- Dental Claim Form
- Direct Deposit Form
- HIPAA Companion Guide
- Humana Independent Review Request Form
- Initial Assessment Form Criteria
- Initial Assessment Form (IAF)
- Initial Clinical Exam
- Instructions for Dental Claim Form
- Medical and Dental History
- Provider Change Form
- Recall Examination Form
- Request for Transfer of Records

7.0 APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org

Association for Electronic Health Care Transactions (AFEHCT)

- A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org

Centers for Medicare & Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Health%20_Insurance_Portability_and_Accountability_Act_of_1996
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Health%20_Insurance_Portability_and_Accountability_Act_of_1996

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations and transaction change request system. www.hipaa-dsmo.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html**United States Department of Health and Human Services (DHHS)**

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. https://www.hhs.gov/hipaa/index.html**Washington Publishing Company (WPC)**
  - WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is https://wpc-edi.com/

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

DentaQuest Review Process
(For Prior Authorization or Claims that Require Prepayment Review)

IMPORTANT

For procedures where "Review Required" fields indicate "yes".

"Review Required" means either Prior Authorization or Prepayment review. Prepayment review requires that the provider must submit the indicated documentation to show medical necessity.

The information below explains how and when to submit documentation to DentaQuest. The information refers to the "Review Required," "Benefit Limitations," and "Documentation Required" fields in the Benefits Covered tables (Exhibits). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completion of treatment.

See the SAMPLE text below that reflects when documentation is requested:

Review Required	Benefit Limitations	Documentation Required	When to Submit Documentation
Yes	One per Lifetime per patient. PRIOR AUTHORIZATION IS REQUIRED.	Study model or OrthoCad, X-rays	Send documentation prior to beginning treatment
Yes	One per Lifetime per patient per quadrant. PRE-PAYMENT REVIEW REQUIRED.	Narrative of medical necessity	Send documentation with claim after treatment

See the SAMPLE text below that reflects when documentation is not requested:

Review Required	Benefit Limitations	Documentation Required	When to Submit Documentation
No	One per 12 months per patient.		No documentation needed prior to beginning treatment or with claim after treatment

Exhibit A Benefits Covered for Humana Healthy Horizons® Adult Value-added Benefit

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. Any reimbursement

already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Dental Services are subject to a combined total five hundred dollars ($500.00) benefit maximum per calendar year ($500.00 Annual Benefit Maximum).

Code	Description	Age Limitation	Teeth Covered	Pre-Auth Required	Benefit Limitations	Documentation Required
D0120	Periodic oral examination – Patient of Record	21-99		No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0150	Comprehensive oral examination – New Patient	21-99		No	Limited one (D0150) per 3 years by the same provider. Not reimbursable if (D0120, D0145, D0150) was paid within 6 Month(s) by the same provider.	
D0210	Intraoral - Complete series of radiographic images	21-99		No	One of (D0210, D0330) per 12 Month(s) Per Provider OR Location.	
D0220	Intraoral – Periapical first radiographic image	21-99		No	One (D0220) Per Day Per Patient	
D0230	Intraoral – Periapical each additional radiographic image	21-99		No		
D0240	Intraoral - Occlusal radiographic image	21-99		No	Two of (D0240) per day Per Provider OR Location.	
D0270	Bitewing - single radiographic image	21-99		No		
D0272	Bitewings – 2 Radiographic images	21-99		No	One per (D0272) in 12-month per day Per Provider OR Location. Not allowed within 12-month period (D0210)	
D0273	Bitewings – 3 Radiographic images	21-99		No		
D0274	Bitewings – 4 Radiographic images	21-99		No		
D0330	Panoramic radiographic image	21-99		No	One per (D0210, D0330) per 12 months per Provider OR Location.	

DentaQuest USA Insurance Company, LLC

Exhibit A Benefits Covered for
Humana Healthy Horizons® Adult Value-added Benefit

All services are subject to a $500.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

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	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 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. For providers to bill for a complex occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases 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 AND CORES OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Note: Preventive services shall be covered.

When restorations involving multiple surfaces are requested or performed 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 placed on the prepared tooth and worn while the permanent crown is fabricated for permanent teeth. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. Dental Services are subject to a combined total five hundred dollars ($500.00) benefit maximum per calendar year ($500.00 Annual Benefit Maximum).

Code	Description	Age Limitation	Teeth Covered	Pre-Auth Required	Benefit Limitations	Documentation Required
D2140	Amalgam-one surface only posterior - permanent teeth	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	
D2150	Amalgam-two surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	

Exhibit A Benefits Covered for Humana Healthy Horizons® Adult Value-added Benefit

Code	Description	Age Limitation	Teeth Covered	Pre-Auth Required	Benefit Limitations	Documentation Required
D2160	Amalgam- three surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	
D2161	Amalgam-four surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	
D2330	Resin-based composite, one surface, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2331	Resin-based composite, two surfaces, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2332	Resin-based composite, three surfaces, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with four surfaces, including the surface I.	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2390	Resin-based composite crown, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2391	Resin-based composite - one surface, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2392	Resin-based composite, two surfaces, posterior	21-99	Tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32.	No	One of (D2330, D2331, D2332, 2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2393	Resin-based composite - three surfaces, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	
D2394	Resin-based composite - four surfaces, posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	

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 beyond normal eruptive pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Dental Services are subject to a combined total five hundred dollars ($500.00) benefit maximum per calendar year ($500.00 Annual Benefit Maximum).

Code	Description	Age Limitation	Teeth Covered	Pre-Auth Required	Benefit Limitations	Documentation Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	No		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	No		

Exhibit B Benefits Covered for
Aetna of Louisiana

Diagnostic services include the oral examination, 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 on the same day will be limited to the allowance for a full mouth series. When individual radiographs are bundled to this allowance, they are payable as D0210.
Reimbursement for radiographs is limited to those films 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 good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

All services are subject to a $750.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

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	21 and older		No	One of (D0120, D0150, D0160) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0120, D0150, D0160) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		Yes	One of (D0160) per 1 Lifetime Per patient.	narrative of medical necessity
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Calendar year(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	One of (D0230) per 1 Calendar year(s) Per patient.	
D0240	intraoral - occlusal radiographic image	21 and older		No	One of (D0240) per 1 Calendar year(s) Per patient.	
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	

Exhibit B Benefits Covered for Aetna of Louisiana

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	

Exhibit B Benefits Covered for
Aetna of Louisiana

All services are subject to a $750.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

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	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	

Exhibit B Benefits Covered for
Aetna of Louisiana

Members are eligible for Comprehensive Services sixty (60) days after enrollment and for all other covered dental benefits upon enrollment with Health Plan.

All services are subject to a $750.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

Reimbursement includes local anesthesia. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. 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. A tooth restored more than once within a six month timeframe by the same provider is subject to being bundled with the first restoration.
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.

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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	

Exhibit B Benefits Covered for Aetna of Louisiana

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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.	

Exhibit B Benefits Covered for
Aetna of Louisiana

Members are eligible for Comprehensive Services sixty (60) days after enrollment and for all other covered dental benefits upon enrollment with Health Plan.

All services are subject to a $750.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

Reimbursement includes local anesthesia and routine post-operative care.

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)	21 and older	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		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	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		

Exhibit C Benefits Covered for
Healthy Blue of Louisiana

Diagnostic services include the oral examination, 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 on the same day will be limited to the allowance for a full mouth series. When individual radiographs are bundled to this allowance, they are payable as D0210.
Reimbursement for radiographs is limited to those films 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 good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

All services are subject to a $300.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

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	21 and older		No	One of (D0120, D0150, D0160) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0120, D0150, D0160) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		Yes	One of (D0160) per 1 Lifetime Per patient.	narrative of medical necessity
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Calendar year(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	One of (D0230) per 1 Calendar year(s) Per patient.	
D0240	intraoral - occlusal radiographic image	21 and older		No	One of (D0240) per 1 Calendar year(s) Per patient.	
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	

Exhibit C Benefits Covered for Healthy Blue of Louisiana

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	

Exhibit C Benefits Covered for
Healthy Blue of Louisiana

All services are subject to a $300.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

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	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	

Exhibit C Benefits Covered for
Healthy Blue of Louisiana

Members are eligible for Comprehensive Services sixty (60) days after enrollment and for all other covered dental benefits upon enrollment with Health Plan.

All services are subject to a $300.00 Annual Benefit Maximum . Unused portions of the annual benefit maximum do not roll over to the following calendar year.

Reimbursement includes local anesthesia. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. 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. A tooth restored more than once within a six month timeframe by the same provider is subject to being bundled with the first restoration.
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.

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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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	21 and older	Teeth 1 - 32, 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.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	

Exhibit C Benefits Covered for Healthy Blue of Louisiana

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, 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.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, 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.	