Office Reference Manual

AmeriHealth Caritas
Medicare Advantage 2023

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

DSM USA Insurance Company, Inc.
PO Box 2906
Milwaukee, WI 53201-2906

www.DentaQuest.com/Florida

* DentaQuest is an independent company providing dental benefit management services on behalf of AmeriHealth Caritas Healthcare Plans, Inc.

DentaQuest LLC June 27, 2024

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
05.30.2023	8.00	22	New language that concerns the privacy of provider data that we collect to conduct our business
06.15.2023	Section 18	55	Added ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF MEMBER FINANCIAL RESPONSIBILITY CONSENT FORM at end of section 18

DSM USA Insurance Company, Inc.
Address and Telephone Numbers

DentaQuest Corporate Office Address:
96 Worcester Street
Wellesley Hills, MA 02481

Florida Provider Services:
DentaQuest General Provider Services Queue:
(877) 468-5581

Email Addresses:
Claims Questions:
denclaims@DentaQuest.com

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

Fraud Hotline:
(800) 237-9139

AHCA Fraud Hotline:
(866) 966-7226

Review Requests should be sent to:
DentaQuest – UM Department
PO Box 2906
Milwaukee, WI 53201-2906

Non-Emergent Review Fax:
(262) 241-7150 or (888) 313-2883

ER Review Fax line:
(262) 387-3736

Credentialing:
PO Box 2906
Milwaukee, WI 53201-2906
Fax: (262) 241-4077

Credentialing Hotline:
(800) 233-1468

General TTY Number:
(800) 466-7566

Claims should be sent to:
DentaQuest - Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Direct entry on the web –
www.dentaquest.com

Or,

Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

Short Procedure Unit (SPU) for review of Operating Room (OR) cases:
DentaQuest - SPU Department
PO Box 2906
Milwaukee, WI 53201-2906
Fax line: (262) 834-3575

Provider Appeals:
DentaQuest – Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: (262) 834-3452

AmeriHealth Caritas Medicare Member Services (Primary):
833-955-3421

DentaQuest Florida Member Services (Secondary):
833-535-3767

DentaQuest

DSM USA Insurance Company, Inc.

The Florida Patient's Bill of Rights and Responsibilities

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

Florida law requires that your health care provider or health care 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 Florida 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.

DSM USA Insurance Company, 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. If a recommended course of treatment is not covered, e.g., not approved by Plan/DENTAQUEST, the participating Provider must 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. To 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
Table of Contents

Section		Page
1.00	Introduction	6
2.00	General Definitions	6
3.00	Patient Eligibility Verification Procedures	8
3.01	Plan Eligibility	8
3.02	Member Identification Card	9
3.03	DentaQuest's Eligibility Systems	9
4.00	Primary Care Providers and Specialty Providers	11
4.01	Keep your Practice Profile Current	11
4.02	Assignment of Members to Providers	11
4.03	PCP Referral NOT REQUIRED for Specialty Treatment	11
4.04	Emergency Care Requirements (All Plans)	12
4.05	Office Reference Manual (ORM) Distribution	13
5.00	Participating Hospitals	14
5.01	Hospital Case Management	14
5.02	Behavior Management	14
6.00	Payment for Non-Covered Services	15
7.00	Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data	16
7.01	Electronic Attachments	16
7.02	Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review	17
7.03	Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Internet Website	17
7.04	Electronic Claim Submission via Clearinghouse	18
7.05	HIPAA Compliant 837D File	18
7.06	NPI Requirements for Submission of Electronic Claims	18
7.07	Paper Claim Submission	19
7.08	Coordination of Benefits (COB)	19
7.09	Filing Limits	19

7.10 Voiding, Canceling or Deleting Claims 20

7.11 Receipt and Audit of Claims 20

7.12 Direct Deposit 20

8.00 Health Insurance Portability and Accountability Act (HIPAA) 21

8.01 HIPAA Companion Guide 22

9.00 Member & Provider Inquiries, Complaints, Grievances & Appeals 23

10.00 Utilization Management Program 24

10.01 Introduction 25

10.02 Community Practice Patterns 25

10.03 Evaluation 25

10.04 Results 26

10.05 Fraud and Abuse 26

10.06 Critical Incident Reporting 27

Dental Office Adverse Incident Report Form 28

10.07 Human Trafficking 31

11.00 Quality Improvement Program 33

12.00 Credentialing 34

12.01 Termination 35

13.00 The Patient Record 35

13.01 Electronic Health Record 38

14.00 Patient Recall System Requirements 38

15.00 Radiology Requirements 39

15.01 Criteria for Radiographs 41

16.00 Clinical Criteria 41

16.01 Criteria for Dental Extractions 43

16.02 Criteria for Cast Crowns 45

16.03 Criteria for Endodontics 46

16.04 Criteria for Review of Operating Room (OR) Cases 47

16.05 Criteria for Removable Prosthodontics (Full and Partial Dentures) 49

16.06 Criteria for the Excision of Bone Tissue..... 50

16.07 Criteria for the Determination of a Non-Restorable Tooth..... 50

16.08 Criteria for General Anesthesia and Intravenous (IV) Sedation 51

16.09 Criteria for Periodontal Treatment..... 51

17.00 Cultural Competency Program..... 53

18.00 Reimbursement of Services Rendered 53

APPENDIX A – Additional Resources 55

APPENDIX B - LINKS TO ONLINE HIPAA RESOURCES..... 56

APPENDIX C – Covered Benefits 57

DentaQuest Review Process 58

BENEFIT EXHIBITS

FL AmeriHealth Caritas VIP Care (HMO D-SNP)……Exhibit A

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: the State of Florida.

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: is 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: means the document that outlines the benefits available to Members.

Provider: means 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: is 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 **DSM USA Insurance Company, Inc.**.

Urgent Medical Situations: is defined as any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

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 and has the following rights:

The rights to -

(i) Receive information in accordance with s. 438.10.
(ii) Be treated with respect and with due consideration for his or her dignity and privacy.
(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under contract because of moral or religious objections are set forth in s. 438.10(g)(2)(ii)(A) and (B).)
(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

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 AmeriHealth I.D. Card:

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/Florida. 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 Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply go to the website at www.DentaQuest.com/Florida. 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(877) 468-5581. 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(877) 468-5581 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, i.e. 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 6 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.

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

Directions for using DentaQuest's IVR to verify eligibility:
Entering system with Tax and Location ID's

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

If you are having difficulty accessing either the IVR or website, please contact the Provider Services Department at 1 (877) 468-5581. They will be able to assist you in utilizing either system.

4.00 Primary Care Providers and Specialty Providers

For the Medicare program, Primary Care Providers (PCPs) include general dentists. Specialty providers include endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists

4.01 Keep your Practice Profile Current

Providers are responsible for contacting DentaQuest to report any changes in their practice.

Keeping your contact information updated is essential for ensuring appropriate access to care for our members. DentaQuest is committed to monitor impact on our network dental practices and member's ability to access care.

DentaQuest conducts surveys each quarter to ensure you are providing timely access to appointments and that your demographic information is up to date in our system. Remember, most up-to-date information is important to us, but more significantly it impacts our members.

It is essential that DentaQuest maintains an accurate provider database in order to ensure proper payment of claims, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members.

Any limitations to or changes in daily operations, including scheduling and available services; and the extent to which the office may be available for services, should be reported to DentaQuest immediately. Optimum patient care, especially during periods of crisis, requires accurate and prompt communication from our partners.

Any changes should be reported to DentaQuest by completing our Provider Update Form (click here) and sending by fax to 262-241-4077 or via e-mail to Standardupdates@dentaquest.com.

4.02 Assignment of Members to Providers

Medicare plans do not require that members be assigned to PCPs.

4.03 PCP Referral NOT REQUIRED for Specialty Treatment

Participating primary care dentists will NOT be required to submit a referral request to DentaQuest when referring an AmeriHealth member for consultation or treatment to a specialist provider.

Specialist providers may treat AmeriHealth members without a system referral from DentaQuest. DentaQuest will not require a referral to approve treatment and process payment for covered benefits.

Remember to Verify Member Eligibility:
Please verify member eligibility on the date of service when treating members. You can easily verify member eligibility through the Provider Web Portal (PWP). Log onto www.DentaQuest.com and click on "Dentist". You can also verify member eligibility through the IVR system 24 hours a day, 7 days a week by calling 1-877-468-5581 and following the prompts. *Verification of Eligibility is not a guarantee of payment.
If members have any questions or concerns regarding their dental plan, please direct them to our dedicated AmeriHealth Member Services Toll-Free Number, (833) 535-3767, for assistance.

Please contact DentaQuest at 1-877-468-5581 should you have any questions or concerns regarding the information above.

4.04 Emergency Care Requirements (All Plans)

In providing for emergency services and care as a covered service, DentaQuest shall not:

1. Require a referral or prior authorization for emergency service and care.
2. Indicate that emergencies are covered only if care is secured within a certain period of time.
3. Use terms such "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
4. Deny payment based on the member's failure to notify DentaQuest in advance or within a certain period of time after the care is given.

Emergency Dental Condition – a dental or oral condition that requires immediate service for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

Emergency Dental Services – those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structure (periodontal membrane, Gingival, alveolar bone), jaws, and tissues of the oral cavity.

Urgent Care – those problems, which, though not life threatening, could result in serious injury or disability unless attention is received or do substantially restrict a member's activity.

Hospital Emergency Services

When a member is present at a hospital seeking emergency services and care, the determination of as to whether an emergency dental condition exists shall be made, for the purpose of treatment, by a dentist or a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the hospital dentist or physician. The dentist or physician, or appropriate personnel shall indicate in the patient's chart the results of the screening, evaluations, and examination.

If the member's primary care dentist responds to the notification, the hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient, in accordance with federal law to determine if the patient is a member of DentaQuest, if emergency services and care are not delayed.
DentaQuest shall compensate the dental provider for any dental services that are incidental to the screening, evaluation, and examination that are reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency dental condition.

DentaQuest shall compensate the dental provider for emergency dental services and care as long as member was eligible for services at time of treatment and services provided were medically necessary. If a determination is made that an emergency dental condition does not exist, DentaQuest is not responsible for payment for services rendered subsequent to that determination.

DentaQuest shall not deny payment for emergency services and care.

Emergency Treatments and Authorizations

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings. After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation. Please FAX this to 262-241-7150.

DentaQuest will process emergency authorization requests as high priority. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

4.05 Office Reference Manual (ORM) Distribution

Providers upon entering into the full credentialing process are provided direction on obtaining the Office Reference Manual (ORM) via print (free of charge) and also thru our portal. During the onboarding process providers are coached on where to find the clinical information, claims submission process, recredentialing process, benefit information and all other critical needs as described here in the manual. In addition, DentaQuest has multiple on the ground representatives that are also in the field weekly to assist them in the usage of this distribution. Providers if you are in need of a new ORM or education, please utilize one of the below forums:

1. Contact their local Provider Engagement Representative
2. Email floridaproviders@DentaQuest.com
3. Contact the DentaQuest Provider Services Center at (877) 468-5581
4. Visit www.DentaQuest.com/Florida

5.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office.

Please refer to section 18.05, Criteria for Review of Operating Room (OR) cases, of this ORM for information on Operating Room (OR) criteria.

5.01 Hospital Case Management

All non-emergency hospital cases require review and approval by DentaQuest. Only cases with the following conditions will be considered:

- Medically Compromised Patients
- Severe Behavior Management Cases
- Complex Restorative Cases

In the event that any procedures are not consistent with our guidelines, DentaQuest reserves the right to deny the prior authorization.

5.02 Behavior Management

Indications for Behavior Management include patients who require immediate diagnosis and/or limited treatment and cannot cooperate due to a *mental* or *physical* disability.

**American Academy of Pediatric Dentistry. Guideline on Behavior Management Reference Manual 2002-2003.*

Member special needs considerations

- Providers must make efforts to understand the special needs required by members. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease (ESRD), isolation, depression and polypharmacy are some of the challenges facing these members each day

- Recognizing the significant needs of members, Health plans incorporates person-centered care planning, coordination and treatment in our care coordination program.

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.

- The member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.

- The Health Plan's case manager leads the member's MDT and links closely to the member's PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the member's care.

- Our Health Plan's predictive model, based on claims history and analytics, is used to determine each member's risk level and level of intervention required in order to channel the member to the required level of coordination.

- A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.

A narrative showing medical necessity must accompany a claim for Behavior Management (code D9920) for consideration of payment from DentaQuest. The narrative should describe the mental or physical disability of the patient; the management problem and the technique utilize to manage the behavior.

DentaQuest does not reimburse for behavior management if:

1. Billed routinely every time the recipient visits the office; or *
2. Billed with either sedation or analgesia on the same date of service.*

Routine use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.

Please note the following:

- Dentist must not restrain children without formal training in medical immobilization.
- Dental auxiliaries must not use restraining devices to immobilize children.

Criteria for Medical Immobilization including Papoose Boards (ADA code D9920)

Written and Signed Informed Consent from a legal guardian is required and needs to be documented in the patient record prior to this procedure. The specific nature of the recipient management problem and the technique utilized must be documented in writing in the recipient's dental record.

Techniques acceptable for D9920 include:

1. Tell-show-do
2. Positive reinforcement or abnormal amount of time consumed
3. Required two or more personnel to assure safety of child and staff
4. Papoose or Pedi-wrap

6.00 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Health Plan 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.

In order to ensure your office is able to bill the member please follow the guidelines below.

- CMS has indicated members are only to be financially responsible for covered or non-covered services if there is a denied pre-service determination on file.
- Offices must submit pre-service determination requests for covered or non-covered services prior to billing members for covered or non-covered services.
- Once pre-authorization is received DentaQuest will review and appropriately deny. DentaQuest must deny the pre-service determination before you are able to bill the member. If DentaQuest does not conduct the review, then you cannot bill the member.

Why is this information important?

- The patient will be personally responsible for full payment if Medicare denies payment for a specific procedure or treatment only if you have a denied determination from DentaQuest.
- It also gives the patient the opportunity to accept or refuse the item or service and protects the patient from unexpected financial liability if Medicare denies payment.
- It also offers the patient the right to appeal insurance decision.

Medicare members are entitled to receive pre-service notification from their health and dental plans as to any out of pocket expense prior to receiving the service. While a provider could use the Consent form, it cannot be in lieu of requesting a prior authorization from us. If the provider does not first obtain a written denial from us, they cannot bill the member.

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

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

Providers have 365 days from the date of service to submit claims to DentaQuest for all Medicare plans.

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 in the Officer Reference Manual (ORM) 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, 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/Florida)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

DentaQuest utilizes claims submissions and information to collect encounter data.

7.01 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, go to https://nea-fast.com/ or call NEA at: 1(800) 782-5150.

7.02 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 https://nea-fast.com/ 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 5 or more radiographs submitted at one time. If 5 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 2012 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.

7.03 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/Florida. 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 **1-877-468-5581**. 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 (800) 417-7140 or via e-mail at: EDITeam@GreatDentalPlans.com.

7.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

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

7.05 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@GreatDentalPlans.com to inquire about this option for electronic claim submission.

7.06 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://nppes.cms.hhs.gov/NPPES/Welcome.do 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 NPI's. 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 is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

7.07 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms (2012 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 NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:
DentaQuest – Claims
PO Box 2906
Milwaukee, WI 53201-2906

7.08 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.

7.09 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.

7.10 Voiding, Canceling or Deleting Claims

DentaQuest is required by CMS to maintain an audit trail for voided, canceled and deleted claims. As a result, DentaQuest may only cancel, void, or delete claims that are not able to be processed for acceptable reasons. Below are the only **acceptable** reasons in which a provider could contact DentaQuest to void, cancel or delete a claim:

1. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
2. The patient's address is missing.

DentaQuest must deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons. Below are **unacceptable** reasons in which a provider could NOT contact DentaQuest to void, cancel or delete a claim.

1. A provider notifies DentaQuest that claim(s) were billed in error and requests the claim be deleted.
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review.
3. The patient's name does not match any Health Insurance Claim Number (HICN).
4. A claim meets the criteria to be returned as not able to be processed under the incomplete or invalid claims instructions in the Medicare Claims Processing Manual, Chapter 1, Section 80.3.2.ff, which is available on the CMS website - http://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/clm104c01.pdf

If a provider realizes that any of the **unacceptable** scenarios above are applicable, the provider must submit a formal grievance to DentaQuest so that DentaQuest can recoup funds from the provider. Once funds have been recouped, the provider must submit the corrected claim to DentaQuest for proper processing and payment.

7.11 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.

7.12 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/Florida).
- 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 Mail:
DentaQuest, LLC - ATTN: Provider Updates
PO Box 2906
Milwaukee, WI 53201-2906

Via Fax: (262) 241-4077

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:

Steps:

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

8.00 Health Insurance Portability and Accountability Act (HIPAA)

Use of Your Information

As a Participating Provider or a Participating Practice, you authorize DentaQuest, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal

information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this dental ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose Participating Practice's and Participating Provider's information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose such personal information to third parties, we require them to protect the privacy and security of this information.

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our participating providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its Participating Provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards recognized by the American Dental Association's (ADA) Current Dental Terminology (CDT) codes. Effective the date of this manual, DentaQuest will require participating providers to submit all claims with the current ADA/CDT codes listed in this manual. In addition, all paper claims must be submitted on the current claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Services Department at (877) 468-5581 or via e-mail at denelig.benefits@DentaQuest.com.

8.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.DentaQuest.com/Florida. Once you have entered the website, click "LOGIN" in the top right corner. You will then be able to log in using your ID and password. Once you have logged in, click

on the link named “Related Documents” where you will find the HIPAA Companion Guide (located under the picture on the right hand side of the screen).

9.00 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 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 an enrollee 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 enrollee’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 it becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance**:** A grievance is 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 enrollee’s rights.

Appeal – An appeal is a formal request from an enrollee 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, 8:00am to 5:30pm. 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 are notified in writing of the resolution (i.e. Plan, Member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

The Complaints/Grievances Coordinator receivesMember 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 in the table in Section E below.

Provider shall comply with the complaints and appeals processes for the applicable program as set forth in the DentaQuest Office Reference Manual. To cooperate and provide Plan, DentaQuest, government agencies and any external review organizations ("Oversight Entities") with access to each Member's dental records at no cost to the requesting agency within 24 hours of the request for the purposes of quality assessment, service utilization and quality improvement, investigation of Member complaints or grievances or as otherwise is necessary or appropriate.

C. Provider Complaints/Grievances/Appeals/Dispute:

Contracted providers have a right to file an appeal for denied claims (which include prepayment review process), prior authorizations and/or referral determinations in accordance with FLA.STAT.§ 641.3155. 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, PO Box 2906, Milwaukee, WI 53201-2906. Provider Appeals Fax line: (262) 834-3452. Providers can also call (877) 468-5581 Monday through Friday, 8:00am to 5:30pm to file their complaint and/or appeals.

D. Provider Complaints concerning non-claims issue:

Allowing providers forty-five (45) days to file a written complaint for issues that are not about claims; Within three (3) business days of receipt of a complaint, notifying the provider (verbally or in writing) that the complaint has been received and the expected date of resolution; Documenting why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and Resolving all complaints within thirty (30) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

E. Member Complaints/Grievances/Appeals:

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

For a **Standard Appeal**: Mailing Address:

AmeriHealth Caritas VIP Care
P.O. Box 80109
London, KY 40742

Fax: 1-855-221-0046

For a **Fast Appeal**:
Phone: 1-833-433-3767 - TTY Users Call: 711 and/or Fax: 1-855-221-0046

F. Policy and Procedures:

Copies of DentaQuest's policies and procedures can be requested by contacting Provider Services at 1 (877) 468-5581.

10.00 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 government. The

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

UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that results in underutilization. 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.

10.01 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. In Medicare, since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance. Additionally, since these dollars are federal in nature, the Centers for Medicare and Medicaid expect DentaQuest and other plans to weed out any fraud and abuse.

UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that results in underutilization. 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.

10.02 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 healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal 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.

10.03 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

10.04 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.

10.05 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 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 should be reported to DentaQuest.

Health care fraud and abuse occurs when someone knowingly submits or helps someone else submit false information related to a health care claim. Typical examples include:

- Filing claims for services not provided
- Forgoing receipts for altering information on original receipts
- Embellishing or lying about services provided or received
- Borrowing a subscriber's health plan identification card
- Altering of diagnosis or other records
- Billing for a more costly service than was actually performed (upcoding) or billing each stage of a procedure separately (unbundling)

The Utilization Review department performs compliance audits based on grievances, complaints or as the result of a Focused Review.

To report suspected fraud or abuse, please contact DentaQuest's Fraud Hotline at 800-237-9139 (or Anonymous Fraud Hotline at 866-654-3433) or write to:

Utilization Review Department
DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

Additional information of DentaQuest's fraud and abuse program can be found at: http://www.dentaquest.com/report-fraud/

All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Also, DentaQuest has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

All services, provided directly or indirectly under the Contract, shall be performed within the borders of the United States and its territories and protectorates. This includes but is not limited to dental laboratory services. DentaQuest expects that all FL providers will operate in accordance with all Medicaid rules, regulations and policies.

10.06 Critical Incident Reporting

DentaQuest includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members. Participating providers should:

- Identify a critical and/or advise incident. Examples include major medication error; death, major illness or injury resulting from a dental procedure; wrong surgical procedure, wrong site of wrong patient; surgical procedure to remove foreign objects remaining from a surgical procedure; involvement with law enforcement; altercations requiring surgical intervention and/or elopement/missing patient.
- Report the critical and/or adverse incident to the appropriate entity (e.g., police, adult protective services).
- Call 911 if the member is in immediate danger.
- Report the critical and/or adverse incident to DentaQuest's Customer Service department at 1-877-468-5581 and/or your Provider Engagement Representative within 24 hours of identifying the incident. Please fill out the Critical Incident Report Form located on the next page or you can find it on the Provider Web Portal.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.

DentaQuest has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

DENTAL OFFICE ADVERSE INCIDENT REPORT FORM

Mail: Complaints & Grievance Dept.: PO Box 2906 Milwaukee, WI 53201-2906
Email: FloridaProviders@dentaquest.com **Fax**: 1-262-387-3734

Adverse Incident - An injury of an enrollee occurring during delivery of Dental Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

I. DENTAL OFFICE INFORMATION

Name of office: _____

Street Address: _____

City, Zip Code and County: _____ Telephone:_____

Name of Dentist: _____ License Number: _____

II. PATIENT INFORMATION

Patient Name: _____ Age: _____Gender:_____

☐ Medicaid ☐ Medicare ☐ Other: _____

Patient's Address:_____

Patient Identification Number: _____

Diagnosis: _____

Date Office of Visit: _____Purpose Office of Visit:_____

III. INCIDENT INFORMATION

Incident Date and Time: _____ Location of Incident: _____

☐ Dental Office ☐ Hospital/Surgical Center ☐ Other: _____

Note:

If the incident involved a death, was the medical examiner notified? *(circle one)* Yes No

Was an autopsy performed? *(circle one)* Yes No

A) Describe circumstances of the incident (narrative) (use additional sheets as necessary for complete response):

_____
_____
_____
_____

DENTAL OFFICE ADVERSE INCIDENT REPORT FORM (*continued*)

B) Dental Procedure

1) Surgical, diagnostic, or treatment procedure including CDT code or codes being performed at time of incident:

_____
_____
_____
_____

2) Accident, event, circumstances, or specific agent that caused the injury or event:

_____
_____
_____
_____

3) Resulting injury:

_____
_____
_____
_____

List any equipment used if directly involved in the incident (Use additional sheets as necessary for complete response):

_____
_____
_____
_____

Outcome of Incident (Please check)

☐ Death	☐ Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition
☐ Brain Damage	☐ Limitation of neurological, physical, or sensory function
☐ Spinal Damage	☐ Any condition that required the transfer of the patient to a hospital
☐ Surgical procedure performed on the wrong patient	Outcome of transfer – e.g., death, brain damage, observation only:
☐ Permanent disfigurement	_____
☐ Fracture or dislocation of bones or joints	Name of facility to which patient was transferred:
☐ Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care	_____
☐ Any condition requiring surgical intervention to correct or control	

List all persons, including license numbers if licensed, locating information and the capacity in which they were involved in this incident, this would include anesthesiologist, support staff and other health care providers:

_____
_____

_____
_____

DENTAL OFFICE ADVERSE INCIDENT REPORT FORM (*continued*)

List witnesses, including license numbers if licensed, and locating information if not listed above:

_____
_____
_____
_____

IV. ANALYSIS AND CORRECTIVE ACTION

A) Analysis (apparent cause) of this incident (use additional sheets as necessary for complete response):

_____
_____
_____
_____

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response):

_____
_____
_____
_____

V. SIGNATURE

_____ _____

SIGNATURE OF DENTIST/LICENSEE SUBMITTING REPORT **LICENSE NUMBER**

_____ _____

DATE REPORT COMPLETED **TIME REPORT COMPLETED**

10.07 Human Trafficking

DentaQuest includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members.

Participating providers should:

- Identify a critical and/or advise incident. Examples include major medication error; death, major illness or injury resulting from a dental procedure; wrong surgical procedure, wrong site of wrong patient; surgical procedure to remove foreign objects remaining from a surgical procedure; involvement with law enforcement; altercations requiring surgical intervention and/or elopement/missing patient.
- Report the critical and/or adverse incident to the appropriate entity (e.g., police, adult protective services).
- Call 911 if the member is in immediate danger.
- Report the critical and/or adverse incident to DentaQuest's Customer Service department at 1-877-468-5581 and/or your Provider Engagement Representative within 24 hours of identifying the incident.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.

DentaQuest has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

Human Trafficking includes, but is not limited to:

- A scripted or inconsistent history
- Unwilling or hesitant to answer questions about the injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact
- Resistant to assistance or demonstrates hostile behavior
- Unable to provide his/her address
- Not aware of his/her location, the current date or time
- Not in possession of his/her identification documents
- Not in control of his or her own money
- Not being paid or wages are withheld

Indicators of abuse, neglect and exploitation:

Physical indicators

1. Unexplained bruises or welts:
   - On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
   - Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas

2. Unexplained fractures:
   - To skull, nose, facial structure, in various stages of healing
   - Multiple or spiral fractures

3. Unexplained burns:
   - Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
   - Immersion burns (socklike, glovelike, doughnut shaped on buttocks)

- Patterned like objects (electric burner, etc.)

4. Unexplained lacerations:
   - Mouth, lips, gums, eye or to external genitalia

5. Sexual abuse:
   - Difficulty in walking/sitting
   - Torn, shredded or bloody undergarments
   - Bruises or bleeding in external genitalia, vaginal or anal areas
   - Venereal disease
   - Pregnancy

6. Other:
   - Severe or constant pain
   - Obvious illness that requires medical or dental attention
   - Emaciated (so that individual can hardly move or so thin bones protrude)
   - Unusual lumps, bumps or protrusions under the skin
   - Hair thin as though pulled out, bald spots
   - Scars
   - Lack of clothing
   - Same clothing all of the time
   - Fleas, lice on individual
   - Rash, impetigo, eczema
   - Unkempt, dirty
   - Hair matted, tangled or uncombed

Behavioral indicators

1. Destructive behavior of victim:
   - Assaults others
   - Destroys belongings of others or themselves
   - Threatens self-harm or suicide
   - Inappropriately displays rage in public
   - Steals without an apparent need for the things stolen
   - Recent or sudden changes in behavior or attitudes

2. Other behavior of victim:
   - Afraid of being alone
   - Suspicious of other people and extremely afraid others will harm them
   - Shows symptoms of withdrawal, severe hopelessness, helplessness
   - Constantly moves from place to place
   - Frightened of caregiver
   - Overly quiet, passive, timid
   - Denial of problems

3. Behavior of family or caregiver
   - Marital or family discord
   - Striking, shoving, beating, name-calling, scapegoating
   - Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible
   - Denial of problems
   - Recent family crisis
   - Inability to handle stress

- Recent loss of spouse, family member or close friend
- Alcohol abuse or drug use by family
- Withholds food, medication
- Isolates individual from others in the household
- Lack of physical, facial, eye contact with individual
- Changes doctor frequently without specific cause
- Past history of similar incidents
- Resentment, jealousy
- Unrealistic expectations of individual

Providers are required to report adverse incidents to the agency immediately but not more than 24 hours of the incident. Reporting will include information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee. It is your responsibility as the provider to ensure that abuse, neglect and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with the plan (managed care organization) enrollees. You may be requested to make such documentation available.

You may use the "Adult Abuse, Neglect and Exploitation Guide for Professionals" as a training tool. It is available at:

http://www.Dcf.State.Fl.Us/programs/aps/docs/guideforprofessionalsrevisedjune2009.pdf.

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day, seven days a week to the central abuse hotline at 1-800-96-ABUSE (1-800-962-2873). You may also make a report online at:

http://www.Dcf.State.Fl.Us/abuse/report/index.asp.

When reporting suspected or confirmed abuse, neglect, or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and gender;
- Physical, mental or behavioral indications that the person is infirmed or disabled;
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes);
- Relationship of the alleged person responsible to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
- Medicaid managed care organizations may be required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation.

11.00 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 (i.e. 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(877) 468-5581 or via e-mail at: denelig.benefits@DentaQuest.com.

Florida Medicaid defines a quality enhancement as: "Certain health-related, community-based services to which the Prepaid Dental Health Plan must offer and coordinate access to its enrollees." In an effort to improve the oral health of its enrollees and reduce dental disease, DentaQuest, in addition to the covered services specified in the Medicaid program, will develop QE programs for its enrollees. QE programs are general dental wellness programs targeted specifically toward enrollees under the age of twenty-one (21). Such QE programs t may be pilot programs and located in certain areas of the state; or may roll out statewide once the program is deemed a best practice. Should DentaQuest develop such QE programs it will offer and coordinate access and educate providers of such programs where applicable.

12.00 Credentialing (Policies 300 Series)

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to National Committee for Quality Assurance (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 300.004)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

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

Discipline of Providers (Policy 300.013)

Procedures for Discipline and Termination (Policies 300.017-300.021)300.004 & 300.013

Recredentialing (Policy 300.009)

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 (877)468-5581 or via e-mail at denelig.benefits@DentaQuest.com.

12.01 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 sixty (60) days written notice prior to discontinuing seeing members. Additionally, the provider must complete any procedures that are in progress or assist DQ in transferring member to another DQ provider.

13.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:
   - Registration data including a complete health history
   - Medical alert predominantly displayed inside chart jacket
   - Initial examination data
   - Radiographs
   - Periodontal and Occlusal status
   - Treatment plan/Alternative treatment plan
   - Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations
   - 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:
   - Health history
   - Medical alert
   - Examination/Recall data
   - Periodontal status
   - 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:

   - Patient's first and last name
   - Date of birth
   - Sex
   - Address
   - Telephone number

- Name and telephone number of the person to contact in case of emergency
- Information regarding the primary language of the enrollee
- Information related to the member's needs for translation services

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

    - Current medical treatment
    - Significant past illnesses
    - Current medications
    - Drug allergies
    - Hematologic disorders
    - Cardiovascular disorders
    - Respiratory disorders
    - Endocrine disorders
    - Communicable diseases
    - Neurologic disorders
    - Signature and date by patient
    - Signature and date by reviewing dentist
    - History of alcohol and/or tobacco usage including smokeless tobacco, and drugs/substances
    - Summary of significant surgical procedures.
    - Treating provider's signature and/or initials must be documented on each date of service
    - 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:

    - Significant changes in health status
    - Current medical treatment
    - Current medications
    - Dental problems/concerns
    - 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:

    - Health problems which contraindicate certain types of dental treatment
    - Health problems that require precautions or pre-medication prior to dental treatment
    - Current medications that may contraindicate the use of certain types of drugs or dental treatment
    - Drug sensitivities
    - 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:

    - Blood pressure (Recommended)
    - Head/neck examination
    - Soft tissue examination
    - Periodontal assessment

- Occlusal classification
- 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:

    - Blood pressure (Recommended)
    - Head/neck examination
    - Soft tissue examination
    - Periodontal assessment
    - Dentition charting

7. Radiographs which are:

    - Identified by patient name
    - Dated
    - Designated by patient's left and right side
    - 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:

    - Procedure
    - 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:

    - Periodontal pocket depth
    - Furcation involvement
    - Mobility
    - Recession
    - Adequacy of attached gingiva
    - Missing teeth

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
    - Gingival status
    - Amount of plaque
    - Amount of calculus
    - Education provided to the patient
    - Patient receptiveness/compliance
    - Recall interval.
    - Date

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

    - Provider to whom consultation is directed
    - Information/services requested

- Consultant's response

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

    - Date of service/procedure
    - 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.
    - Type and dosage of anesthetics and medications given or prescribed.
    - Localization of procedure/observation. (tooth #, quadrant etc.)
    - Signature of the Provider who rendered the service.

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

    - Patient examination
    - Treatment plan
    - 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.

13.01 Electronic Health Record

The use of Electronic Health Records is highly encouraged and promotes the ease of administering the DentaQuest dental programs.

14.00 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 provided immediately.
- Urgent care must be available within 24 hours.
- Sick care must be available within one week.
- Routine exams must be provided within four weeks of an enrollee's request.

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

15.00 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 of age) 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.

15.01 Criteria for Radiographs

American Dental Association (ADA) and American Association of Pediatric Dentists (AAPD) guidelines promote, 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.

http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_chart.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.

16.00 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. 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 and belief to provide 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.

The clinical criteria presented in this section are the criteria that DentaQuest will use for making medical necessity determinations for prior authorizations, post payment review and retrospective review. In addition, please review the general benefit limitations presented in Exhibit A of this manual for additional information on medical necessity on a per code basis.

Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Prior authorization is required for orthodontic treatment and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center. Some services require pre-payment review, these services are detailed in Exhibit A Benefits Covered in the “Review Required” column.

For all procedures, every Provider in the DentaQuest program is subject to random chart/treatment 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.

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.

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.

16.01 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.

Surgical extractions of erupted teeth are defined as extractions **requiring** elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure in order to remove the tooth. Elevation of mucoperiosteal flap and removal of bone and/or sectioning of the tooth for the **convenience of the provider** is not a surgical extraction.

The removal of primary teeth whose exfoliation is imminent is not a covered benefit. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given. Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit

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. General Practitioner, Pedodontist, or Orthodontist determines patient may need third 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
        - 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.
        - 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 (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
        - Provider must submit narrative and x-rays or photos describing pathology

- Each tooth must show pathology
- Symptomology or impactions without pathology may not be enough

b. Demonstrable need
- Narrative describing need
- Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)

c. Extractions in conjunction with approved orthodontic treatment
- Provider must submit request for extractions from orthodontist
- Needs to be an approved orthodontic case
- To expedite process, provider may also want to submit orthodontic approval

4. General Approval vs. Denial Guidelines
   a. Probable Approval
   - Pathology =
     1. Non-restorable Decay
     2. Tooth erupting on an angle and impinging on 2nd molars
        - An unerupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations **and** substantial (> 50%) root formation.
     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

   - 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
   - Impaction or Symptomology =
     1. Impaction with no other pathology
     2. Pain or discomfort with unknown pathology
   - 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:
   - Resubmit with documentation showing additional clinical evidence for extraction
   - 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.

6. The extraction of primary or permanent teeth does not require authorization unless:
   a. Teeth are impacted wisdom teeth.
   b. Residual roots requiring surgical removal.

c. Surgical extraction of erupted teeth.

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. D7310 will not pay for surgical extracts. Smoothing and contouring of ridges in conjunction with the surgical removal of a tooth is considered an inclusive part of the complete surgical extraction procedure unless rationale is submitted indicating necessity of the additional surgical bone removal. D7310 will pay with simple extractions (D7140). It is set to not pay with surgical extractions (where as part of extraction bone is removed – so alveoloplasty (bone remove and smoothing) with surgical extractions is redundant).

16.02 Criteria for Cast Crowns

Documentation needed for review of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for review: bitewings, periapicals or panorex.

- Treatment rendered without necessary review will still require that sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.

- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.

- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.

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

- Request should include a dated post-endodontic radiograph.

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.

- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Approval for Crowns will not meet criteria if:

- A more cost-effective means of restoration is possible that provides quality care and meets the standard of care means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth does not demonstrate 50% bone support.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay
- An existing crown is present with chipped or fractured porcelain without decay.

16.03 Criteria for Endodontics

Not all procedures require review.

Documentation needed for review of procedure:

- Sufficient and appropriate radiographs clearly showing the adjacent teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

- Root canal treatment limited to permanent teeth or retained primary teeth with no succedaneous permanent teeth.

Approval for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
- Retreatment of previous root canal therapy is a separate procedure (codes D3346, D3347 and D3348) and is generally not a covered service (check the member's plan for covered services).

Other Considerations

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

16.04 Criteria for Review of Operating Room (OR) Cases

All Operating Room (OR) Cases MUST be reviewed.

Provider must submit the following documents for review via fax to DentaQuest's Short Procedure Unit (SPU) at (262) 834-3575 or via mail to DentaQuest - (or DentaQuest SPU Dept.) PO Box 2906 Milwaukee, WI 53201-2906 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:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.

- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, resent 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 PCP narrative, which is submitted with the review request.

16.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for review of procedure:

- Treatment plan, including any planned extractions.
- Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered without necessary will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Fabrication of a removable prosthetic includes multiple steps (appointments). These multiple steps (impressions, try in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic, and as such, not eligible for additional compensation.

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected. Please note, if DentaQuest denies a cast partial denture and notes that we believe the abutment teeth cannot support a cast partial denture (this language does not mean we deny a denture, but instead believe an acrylic partial denture or full denture would be more appropriate and covered.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

The replacement teeth should be anatomically full-sized teeth. Approval for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth

and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After 6 months of denture placement.
- A new prosthesis will not be reimbursed within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
- Relines will be reimbursed once per denture every 36 months.
- Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for approval of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

16.06 Criteria for the Excision of Bone Tissue

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

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to review and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Review requirements:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

16.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.

- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

16.08 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, which could include a physical, medical, developmental or behavioral issue (such as cerebral palsy, epilepsy, mental retardation, Down's syndrome, or situational anxiety that has failed to respond to the lesser methods to prevent or reduce anxiety 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.

16.09 Criteria for Periodontal Treatment

Documentation needed for review of procedure:

Required

- Radiographs – Full Mouth Series.
- Complete periodontal charting with AAP Case Type.

As needed:

- Photos
- Narrative describing unusual or unique features

Per the ADA CDT Dental Procedure Codes manual:

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

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

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

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

Criteria and documentation required:

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, radiographic documentation must indicate the following:
    1. Evidence of noticeable loss of bone support, with or without; **and**
    2. Evidence of root surface calculus.

Gingivectomy or gingivoplasty (D421 and D4211) per the ADA CDT Dental Procedure Codes manual are "indicated to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration."

Criteria and documentation required:

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Intra-oral pictures.
- Narrative

Gross Debridement (D4355) is the gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. Providers may only perform a gross debridement if the deposits on the teeth prevent them from performing an complete oral evaluation. Consequently, a provider should not perform an oral evaluation on the same day he/she performs a gross debridement. In such cases the provider should document the condition with photographs to show medical necessity.

17.00 Cultural Competency Program

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as healthcare 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 issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent 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 staff is 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.

DentaQuest ensures that its staff is 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 all DentaQuest's 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 (877) 468-5581 or via e-mail 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 be experimental or investigational
- reflective of the level of service that can be furnished safely and for which not 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 do not, in itself, make such care, goods or services medically necessary or a covered service.

Oral and Maxillofacial Program (CPT codes)
This service is considered a medical procedure and should be submitted to the member's medical carrier with the appropriate CPT code.

ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF
MEMBER FINANCIAL RESPONSIBILITY

CONSENT FORM

_____

Name of Member (the "Member") – *please print clearly*

_____

Treating Provider (the "Provider") – *please print clearly*

_____

Office/Location Name and Address

The Member or the Member's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program.

Accordingly, the undersigned agrees that the Member or Member's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

Code	**DOS** (if applicable)	**Tooth/Surface/Arch**	**Cost**

Date: _____

Signature of Member or Member's Legal

Representative

Witness:

APPENDIX A – Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at www.DentaQuest.com/Florida. 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
- Initial Clinical Exam
- Medical and Dental History
- Provider Change Form
- Recall Examination Form
- Request for Transfer of Records
- Incident Report Form

APPENDIX B - 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 and 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 www.cms.gov/hipaa/hipaa2/.
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

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. www.hhs.gov/ocr/hipaa

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. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is www.wpc-edi.com/HIPAA

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

APPENDIX C – Covered Benefits

Member's Covered Benefits (See Exhibits)

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations for Members under age 21. Providers with benefit questions should contact DentaQuest's Provider Services Department directly at:

1(877) 468-5581, press option 2

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth and. These codes must be referenced in the patient's file for record retention and review. All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a one surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

Oral and Maxillofacial Program (CPT codes). This service is considered a medical procedure and should be submitted to the member's medical carrier with the appropriate CPT code. The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
(800) 947-4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT manual.

The benefit tables (Exhibits) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service and any other applicable benefit limitations,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim that requires prepayment review or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to review which includes prior authorization or prepayment review

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 1 Lifetime per patient. PRIOR AUTHORIZATION IS REQUIRED.	Study model or OrthoCad, x-rays	Send documentation prior to beginning treatment
Yes	One per 1 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
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

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.
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.

Member copayment is $0 for all covered procedures.
AmeriHealth Caritas's Benefits are based upon a Calendar Year. Calendar Year means January through December.

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) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140) per 6 Month(s) Per patient. Not allowed with routine services.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 6 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 6 Month(s) Per patient.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient. One of (D0210, D0330, D0372) per 5 Calendar year(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0240	intraoral - occlusal radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0270	bitewing - single radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient. One of (D0210, D0330, D0372) per 5 Calendar year(s) Per patient.	
D0340	cephalometric radiographic image	21 and older		No	One of (D0340) per 5 Calendar year(s) Per patient.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient. One of (D0210, D0330, D0372) per 5 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No	Six of (D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330, D0372, D0373, D0374) per 1 Calendar year(s) Per patient.	

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Member copayment is $0 for all covered procedures.
AmeriHealth Caritas Medicare Benefits are based upon a Calendar Year. Calendar Year means January through December.

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.	
D1206	topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1206, D1208) per 6 Month(s) Per patient.	

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twenty-four months. Please consult the following benefit tables for benefit limitations.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, curing, and polishing are included as part of the fee for the restoration.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Member copayment is $0 for all covered procedures.
AmeriHealth's Medicare Benefits are based upon a Calendar Year. Calendar Year means January through December.

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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394, D2990) per 1 Day(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more 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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
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, D2390, D2391, D2392, D2393, D2394) per 1 Day(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2710	crown - resin-based composite (indirect)	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2721	crown - resin with predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2721, D2740, D2751, D2752, D2791) per 5 Calendar year(s) Per patient per tooth. Two of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient per arch. Four of (D2710, D2721, D2740, D2751, D2752, D2791) per 1 Calendar year(s) Per patient.	Pre-operative periapical radiographs
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	One of (D2920) per 5 Calendar year(s) Per patient per tooth. Only after 6 months of initial placement.	
D2952	cast post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2952, D2954) per 5 Calendar year(s) Per patient per tooth. Deny when billed with resin or amalgam restoration.	

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2952, D2954) per 5 Calendar year(s) Per patient per tooth. Deny when billed with resin or amalgam restoration.	

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

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Member copayment is $0 for all covered procedures.
AmeriHealth Caritas Medicare Benefits are based upon a Calendar Year. Calendar Year means January through December.

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 24 Month(s) Per patient per quadrant.	Radiographs, perio charting and photographs
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	Radiographs and perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D4355) per 1 Calendar year(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		No	One of (D4910) per 1 Day(s) Per patient.	

Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member.

Approval for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition.

Approval for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion.

Dentures will not be approved when:
Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.
A preformed denture with teeth already mounted forming a denture module is not a covered service.
Fabrication of a removable prosthetic includes multiple steps (appointments). These multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic, and as such, not eligible for additional compensation.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Member copayment is $0 for all covered procedures.
AmeriHealth Caritas Medicare Benefits are based upon a Calendar Year. Calendar Year means January through December.

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

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130, D5211, D5213) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140, D5212, D5214, D6111) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5110, D5130, D5211, D5213) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5120, D5140, D5212, D5214, D6111) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5110, D5130, D5211, D5213) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5120, D5140, D5212, D5214, D6111) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5110, D5130, D5211, D5213) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5120, D5140, D5212, D5214, D6111) per 5 Calendar year(s) Per patient.	pre-operative x-ray(s)
D5410	adjust complete denture - maxillary	21 and older		No	One of (D5410) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5411	adjust complete denture - mandibular	21 and older		No	One of (D5411) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5421	adjust partial denture-maxillary	21 and older		No	One of (D5421) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5422	adjust partial denture - mandibular	21 and older		No	One of (D5422) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5511	repair broken complete denture base, mandibular	21 and older		No	One of (D5511) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5512	repair broken complete denture base, maxillary	21 and older		No	One of (D5512) per 1 Day(s) Per patient per arch. After 6 months have elapsed since initial placement.	
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	One of (D5520) per 1 Day(s) Per patient per tooth. After 6 months have elapsed since initial placement.	
D5611	repair resin partial denture base, mandibular	21 and older		No	One of (D5611) per 1 Day(s) Per patient per arch.	
D5612	repair resin partial denture base, maxillary	21 and older		No	One of (D5612) per 1 Day(s) Per patient per arch.	
D5621	repair cast partial framework, mandibular	21 and older		No	One of (D5621) per 1 Day(s) Per patient per arch.	
D5622	repair cast partial framework, maxillary	21 and older		No	One of (D5622) per 1 Day(s) Per patient per arch.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	One of (D5630) per 1 Day(s) Per patient per tooth.	
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	One of (D5640) per 1 Day(s) Per patient per tooth.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	One of (D5650) per 1 Day(s) Per patient per tooth.	
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	One of (D5660) per 1 Day(s) Per patient per tooth.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730, D5750) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731, D5751) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5740	reline maxillary partial denture (chairside)	21 and older		No	One of (D5740, D5760) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5741	reline mandibular partial denture (chairside)	21 and older		No	One of (D5741, D5761) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5730, D5750) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5731, D5751) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	One of (D5740, D5760) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	One of (D5741, D5761) per 1 Day(s) Per patient. After 6 months have elapsed since initial placement.	

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

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6013	surgical placement of mini implant	21 and older	Teeth 1 - 32	Yes	One of (D6013) per 5 Calendar year(s) Per patient.	Full mouth x-rays
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D5120, D5140, D5212, D5214, D6111) per 5 Calendar year(s) Per patient.	Full mouth x-rays

Exhibit A Benefits Covered for
FL AmeriHealth Caritas VIP Care (HMO - D-SNP)

Member copayment is $0 for all covered procedures.
AmeriHealth Caritas Medicare Benefits are based upon a Calendar Year. Calendar Year means January through December.

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	One of (D7140) per 1 Lifetime Per patient per tooth.	
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	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7250	surgical removal of residual tooth roots (cutting procedure)	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	One of (D7250) per 1 Lifetime Per patient per tooth.	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 1 Lifetime Per patient per quadrant.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 1 Lifetime Per patient per quadrant.	
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	No	Two of (D7471) per 1 Lifetime Per patient per arch.	
D7472	removal of torus palatinus	21 and older		No	One of (D7472) per 1 Lifetime Per patient.	
D7473	removal of torus mandibularis	21 and older		No	Two of (D7473) per 1 Lifetime Per patient.	
D7485	surgical reduction of osseous tuberosity	21 and older		No	Two of (D7485) per 1 Lifetime Per patient.	
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		No	One of (D7961) per 1 Lifetime Per patient per arch.	
D7962	lingual frenectomy (frenulectomy)	21 and older		No	One of (D7962) per 1 Lifetime Per patient per arch.	
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D7970) per 1 Lifetime Per patient per arch.	