DentaQuest of Georgia, LLC

Amerigroup Community Care

Medicaid Office Reference Manual

Please Refer to Your Participation Agreement for Plans You are Contracted For

PO Box 2906
Milwaukee, WI 53201-2906
800.516.0124
www.dentaquest.com

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

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DentaQuest of Georgia, LLC
Address and Telephone Numbers

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

Provider Services:
800-516-0124

Eligibility or Benefit Questions:
800.516.0124

Claims Questions:
Claims/payment issues:
Fax: 262.241.7379
Claims to be processed:
Fax: 262.834.3589
All other:
Fax: 262.834.3450
Claims questions:
Email: DenClaims@dentaquest.com

Customer Service/Member Services:
800.895.2218

Fraud Hotline:
800.237.9139

TTY/TDD
Amerigroup: 711 relay

Multilingual:
800.600.4441

Provider Claim Appeals should be sent to:
Provider Claim Appeals
PO Box 2906
Milwaukee, WI 53201-2906

Or,

Email:
ProviderClaimAppeals@dentaquest.com

Credentialing
PO Box 2906
Milwaukee, WI 53201-2906

Credentialing Hotline: 800.233.1468

Fax: 262.241.4077

Authorizations should be sent to:
DentaQuest of GA - Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

Prior authorizations for Operating Room Procedures should be sent to:
DentaQuest of GA - Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

Or,

Email:
GAIVSedationRequests@dentaquest.com

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

Electronic authorizations should be sent:
Via the provider web portal:
https://govservices.dentaquest.com/

Or,

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

Electronic Claims should be sent:
Via the provider web portal:
https://govservices.dentaquest.com/

Or,

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

DentaQuest of Georgia, LLC

Statement of Members Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities.

1. All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.

2. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.

3. All Members have the right to fully participate with caregivers in the decision making process surrounding their health care.

4. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

5. All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.

6. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.

7. All Members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.

2. All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

3. All Members, have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

DentaQuest of Georgia, LLC

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 GA CVO credentialing or recredentialing application, upon request.

* * *

Office Reference Manual
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1.00 Patient Eligibility Verification Procedures

1.01 State Eligibility System

Providers must verify the member's eligibility within 72 hours of services being rendered using the State's Eligibility System (website below). Prior to rending services, print out a copy of the member's eligibility from the State's system and keep a copy of it in the member's file. If the claim is denied due to member ineligibility, providers should submit the print out of the member's eligibility the State's Eligibility System with a copy of the claim to DentaQuest by e-mail or standard mail:

E-mail: providerclaimappeal@dentaquest.com
Address:
DentaQuest - Eligibility
12121 North Corporate Parkway
Mequon, WI 53092

Georgia Department of Community Health
www.mmis.georgia.gov
Phone: 800.766.4456

1.02 Plan Eligibility

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

Amerigroup Community Care
Phone: 800.454.3730
Website URL: https://providers.amerigroup.com/GA

1.03 Member Identification Card

Members receive identification cards from their Plan. 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.

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.**

Sample of Amerigroup Community Care I.D. Card

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care. If your PCP is unavailable, go to the nearest urgent care center. If you are deaf or hard of hearing, please call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muéstrela antes de recibir cuidado médico. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Amerigroup para cuidado que no sea de emergencia. Si su PCP no está disponible, vaya al centro de cuidado de urgencia más cercano. Si es sordo o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. Non-par providers must obtain preauthorization for all inpatient/outpatient services. For preauthorizations/billing or pharmacy information, call 1-800-454-3730. For enhanced OP BH requests, fax to 1-888-375-5070. For psych testing request, fax to 1-800-505-1193.
PHARMACIES: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKJA. For technical help, call **Express Scripts** at 1-844-367-6112.

SUBMIT MEDICAL CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

GA05 07/16 **USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**

Effective Date:
Date of Birth:
Subscriber #:

www.myamerigroup.com/GA
Member Name:
Medicaid or PeachCare for Kids® Number:
Primary Care Provider (PCP):
PCP Telephone #:
PCP After Hours #:
PCP Address:
Primary Dental Provider (PDP):
PDP Telephone #:
PDP Address:
Copays may apply for certain services
Vision: **1-866-522-5923** Dental: **1-888-278-7310**
AMERIGROUP Member Services/Nurse HelpLine and Behavioral Health (24 hours a day, 7 days a week): **1-800-600-4441**

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care.
If your PCP is unavailable, go to the nearest urgent care center. If you have questions, call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, please call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muéstrela antes de recibir cuidado médico. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Amerigroup para cuidado que no sea de emergencia. Si su PCP no está disponible, vaya al centro de cuidado de urgencia más cercano. Si tiene alguna pregunta, llame a Servicios al Miembro al 1-800-600-4441. Si es sordo o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. Non-par providers must obtain preauthorization for all inpatient/outpatient services. For preauthorizations/billing or pharmacy information, call 1-800-454-3730.
PHARMACIES: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKJA.
For technical help, call **Express Scripts** at 1-844-367-6112.

SUBMIT MEDICAL CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

GA01 07/16 **USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**

Effective Date:
Date of Birth:
Subscriber #:

FAMILY PLANNING SERVICES

Member Name:
State Identifier #:

MEMBERS: Please carry this card at all times. Show this card before you get medical care covered by the program. You do not need to show this card before you get emergency care. If you have an emergency,call 911 or go to the nearest emergency room. Not all emergency care is covered by this program. Always call your Family Planning Provider for nonemergency family planning care. If you have questions, call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, please call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muestre esta tarjeta antes de recibir atención médica cubierta por el programa. No tiene que mostrar esta tarjeta antes de recibir atención de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. No toda la atención de emergencia está cubierta por este programa. Llame siempre a su Proveedor de Planificación Familiar para atención de planificación familiar que no sea de emergencia. Si tiene alguna pregunta, llame a Servicios al Miembro al 1-800-600-4441. Si es sordo(a) o tiene problemas auditivos, llame al 711.
HOSPITALS: For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
PROVIDERS: For preauthorizations/billing or pharmacy information, call 1-800-454-3730.

PHARMACIES: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKJA
For technical help, call **Express Scripts** at 1-844-367-6112.

SUBMIT MEDICAL CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

GA02 9/15 **USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**

MEMBERS: Please keep this card with your Medicaid ID card. For questions about Resource Mother or Case Management services, please call Member Services at 1-800-600-4441. For medical questions, please call your state Medicaid office at 1-866-211-0950. If you have an emergency, call 911 or go to the nearest emergency room. Always call your doctor for nonemergency care.

MIEMBROS: Conserve esta tarjeta junto con su tarjeta de Identificación de Medicaid. Para preguntas sobre servicios de Madre Tutora (Resource Mother) o Manejo de Casos, llame a Servicios al Miembro al 1-800-600-4441. Para preguntas médicas, llame a la oficina de Medicaid de su estado al 1-866-211-0950. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su médico para atención que no sea de emergencia.

AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.

GA04 10/11

Amerigroup RealSolutions in healthcare

Effective Date:
Date of Birth:
Subscriber #:

RESOURCE MOTHER OUTREACH

Member Name:
State Identifier #:

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for non-emergency care.
If you have questions, call Member Services at 1-800-600-4441. If you are hearing impaired, please call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muestre esta tarjeta antes de recibir atención médica. No tiene que mostrar esta tarjeta antes de recibir atención de emergencia. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP de Amerigroup para atención que no sea de emergencia.
Si tiene alguna pregunta, llame a Servicios al Miembro al 1-800-600-4441. Si tiene deficiencia auditiva, llame al 711.
HOSPITALS: For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.

PROVIDERS: Certain services must be preauthorized. Care that is not preauthorized may not be covered. For preauthorizations/billing or pharmacy information, call 1-800-454-3730.
PHARMACIES: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKJA.
For technical help, call **Express Scripts** at 1-844-367-6112.

SUBMIT MEDICAL CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

GA03 9/15 **USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.**

Effective Date:
Date of Birth:
Subscriber #:

INTERPREGNANCY CARE

Member Name:
State Identifier #:
Primary Care Provider (PCP):
PCP Telephone #:
PCP After Hours #:
PCP Address:

Amerigroup Member Services: **1-800-600-4441**

1.04 DentaQuest Eligibility System

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. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service 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 Customer Service 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 log on to the website at www.dentaquest.com. Once you have entered the website, click on "DentaQuest" and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their 6 digit DentaQuest Location ID, office name and office address. Please refer to your payment remittance or contact DentaQuest's Customer Service Department at 800.516.0124 to obtain your location ID. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line
To access the IVR, simply call DentaQuest's Customer Service Department at 800.516.0124 and press 1 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 Customer Service Representative during regular business hours to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative during regular business hours.

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

Call DentaQuest Customer Service at 800.516.0124.

1. After the greeting, stay on the line for English or press 1 for Spanish.
2. When prompted, press or say 2 for Eligibility.
3. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
4. 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.
5. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
6. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
7. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
8. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 800.516.0124. They will be able to assist you in utilizing either system.

1.05 Health Plan Facility Authorization Phone Number

Providers should submit services to be rendered in an outpatient setting to DentaQuest for pre-authorization. DentaQuest will determine the medical necessity of the request. If approved, DentaQuest will forward the request to Plan for approval of the facility and anesthesia. Each Plan will send the approval for the facility and anesthesia, DentaQuest will return the authorization determination letter for the professional services to be rendered. All facilities must be contracted with Plan for consideration. Requests should be sent in writing to DentaQuest at:

DentaQuest of GA - Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

Or submitted on-line at https://govservices.dentaquest.com/
Email: GAIVSedationRequests@dentaquest.com

1.06 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Member Services Department at the telephone number found on page 2 of this manual.

1.07 Member Transportation

To arrange a ride for a PeachCare for Kids member in any of the three regions, call Southeastrans at 1-800-657-9965.

Georgia Medicaid will provide children with a ride to and from healthcare services. Call the company that serves your area. Call at least 3 days before your appointment if possible. Here are the numbers to call:

- **Atlanta:** 404-209-4000 (Southeastrans)
- **Central:** 1-866-991-6701 (Southeastrans)
- **Southwest:** 1-866-443-0761 (Southwest Georgia Development)

1.08 Medical History Form

It is required that a Medical History Form be completed for each patient and maintained in the patient's medical record. An example of a Medical History Form can be found on page A-20.

2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit "documentation" associated with certain dental services for a Member. Participating Providers will not be paid if this "documentation" is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

A. Expedited Authorizations (Emergency treatment)

In an **emergency** situation, the need to prior authorize services is waived. An Emergency is defined as treatment to ameliorate pain, infection, swelling, uncontrolled hemorrhage and traumatic injury that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

In the event a Provider determines that the fourteen (14) day standard timeframe could seriously jeopardize the Member's life or health, DentaQuest makes an expedited authorization determination and provides notice within twenty-four (24) hours. DentaQuest may extend the twenty-four (24) hour period for up to three (3) Business Days if the Member or the Provider requests an extension, or if DentaQuest justifies to DCH a need for additional information and the extension is in the Member's interest.

A provider may choose to submit for authorization and payment retrospectively in emergency situations. Claims submitted for retro-review must be submitted within thirty (30) calendar days from the date of service.

The retrospective review claim is reviewed by the Benefit Examiner to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and

appropriateness of care. A Dental Director reviews all services denied for medical necessity.

Claims should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

Your submission of "documentation" should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form
- Date of Service

It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

B. Standard Authorizations (Non-emergency treatment)

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan and/or DentaQuest.

Your submission of "documentation" should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number within 14 days from receipt of request. An extension may be granted for an additional fourteen (14) calendar days if the member or provider requests an extension, or if DentaQuest justifies to DCH a need for additional information and the extension is in the member's interest. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

As a reminder, providers must submit a completed authorization form and all required documentation for consideration of a previously denied authorization.

2.02 Primary Care Offices

Primary Care Physicians (PCPs) provide comprehensive Primary Care services to Plan members. PCPs coordinate, monitor and supervise the delivery of Primary Care services to each member.

2.03 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider may bill a Member for non-Covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- The services to be provided;
- DentaQuest, Plan and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.

2.04 Electronic Attachments

A. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization 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 www.nea-fast.com or call NEA at 800.782.5150.

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

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

2.05 Prior Approval Process after ACS/DCH Approval

Step 1: Provider completes their ADA claim form which includes all services that will be rendered

Step 2: Attach the prior approval from ACS/DCH to the claim form

Step 3: Mail these documents to DentaQuest at:
DentaQuest of GA - Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

**If the office has scanning capabilities they can request this via the website by scanning in the prior approval and attaching that document to the authorization form*

Step 4: Provider will receive a written determination letter via mail with the new authorization number that is to be used through DentaQuest. Provider can also receive the new authorization number on DentaQuest's website. Services are not going through the approval process again, instead are being transferred to DentaQuest.

If you have any offices experiencing problems with this process please refer those providers to contact Kim Tenor for assistance.

Please be advised that authorizations are valid for 180 days

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

4.00 Claim Submission Procedures (claim filing options)

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

- Electronic claims via DentaQuest's website (www.dentaquest.com).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

4.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on "DentaQuest", and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their DentaQuest 6 digit Location ID prior to logging in. Once logged in, select "enter a claim now" and enter the Member's applicable information in the field provided. It is NOT necessary to enter the Member's last name and/or first initial; only the identification number, date of birth, and date of service are required. Next you will click on the word "before" that appears below the Member's DOB field to verify eligibility and populate the name fields automatically. Once this information is generated you may now begin to enter the claim line detail to complete the submission.

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

4.02 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.

4.03 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.

4.04 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.

- 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 in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest 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.

4.05 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.

- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

- The 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 date of service must be provided on the claim form for each service line submitted.
- The paper claim must contain an acceptable provider signature.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- 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.
- 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.

Paper Claims should be mailed to the following address:

DentaQuest of GA, LLC-Claims
PO Box 2906
Milwaukee, WI 53201-2906

DentaQuest processes all claims by receipt date.

4.06 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.

4.07 Filing Limits

Georgia timely submission is 6 months from the month of service.

Timely filing for COB is 180 days from the date of denial or payment of the primary carrier's EOB and no longer than 12 months from the month of service.

Timely resubmission of a previously denied claim must be submitted within 6 months from the month in which the service was rendered or within 3 months of the month in which the denial occurred, whichever is later.

4.08 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department 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.

4.09 Direct Deposit

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

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

- Complete and sign the Direct Deposit Authorization Form found on page A-19 of this manual.
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

    - Via Fax – 262.241.4077 **or**

    - Via Mail – DentaQuest of Georgia, LLC.
PO Box 2906
Milwaukee, WI 53201-2906
ATTN: PDA Department

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

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

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

1. Login to the PWP at www.dentaquest.com
2. Under the Documents header, Select **Remittance Documents**
3. Click on the **View Remittance Documents** button to display the remittance notice
4. Click on the **View** button at the right end of the specific remittance that you would like to view
5. The remittance will display on the screen.

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider 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 feral laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 800.341.8478 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right hand side of the screen).

6.00 Inquiries, Complaints and Grievances (Policies 200.010, 200.011, 200.017C, 200.019)

6.01 Provider Complaints and Appeals

DentaQuest adheres to Georgia DCH and Plan requirements related to processing complaints and appeals. Unless otherwise required by Agency and Plan, DentaQuest processes such inquires, complaints, and grievances consistent with the following:

A. **Informal Claim Adjustments or Claims Complaints-** Providers may submit Informal Claim Adjustments or Claim Complaints verbally (by telephone or in person) or in writing. An Informal Claim Adjustment/Claim Complaint is a verbal or written expression by a Provider which indicates dissatisfaction or dispute with DentaQuest's claim adjudication to include the amount reimbursed or regarding denial of a particular service.

B. **Administrative Complaints:** Complaints in reference to administrative functions policies and procedures of the Company and do not include claim or authorization denial issues.

C. **Claim Appeals:** Appeals in reference to a denial issued by Claims for reasons other that lack of authorization or lack of supporting medical information. Providers are offered 30 days to file written appeals in reference to claim denials. DentaQuest will process provider claim appeals within 30 days of receipt.

D. **Pre-Authorization Appeals:** Appeals in reference to a pre-authorization denial issued for a lack of required authorization or lack of supporting medical documentation. Providers may only file an appeal related to the denial of a prior authorization with the member's consent. Provider appeals with member consent shall be deemed a member appeal and handled in accordance with section 6.02.

Claim and pre-authorization appeals may be sent to DentaQuest in writing or e-mail to:

DentaQuest of GA, LLC-Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Providerclaimappeals@dentaquest.com

E. **Administrative Law Hearing** – Providers have 15 days from the date of denial to file for an Administrative Law Hearing. The Notice of Adverse Action contains the address where a Provider's request for an Administrative Law Hearing should be sent. It also notifies the Provider that a request for an Administrative Law Hearing must include the following information:

1. A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
2. Identification of the Action being appealed and the issues that will be addressed at the hearing;
3. A specific statement of why the Provider believes the Contractor's Action is wrong; and
4. A statement of the relief sought.

Administrative Law Hearing requests should be sent to in writing:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

F. **Arbitration** – The Provider can select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If DentaQuest and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless DentaQuest and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

6.02 Member Administrative Reviews and Member Grievances

Administrative Reviews
An Administrative Review is a request for a change in DentaQuest's decision regarding a member's care. Examples include:

- DentaQuest's refusal to pay for something a member feels should be covered
- A dentist didn't provide the care a member feels they need
- A dentist cuts back on services a member had been receiving

Requests for Administrative Reviews may be made by a: member, provider, or a member's representative and must be requested within 30 days of receipt of the adverse decision. Requests for Administrative Reviews may be made orally by contacting the health plan or sent in writing to:

Amerigroup Community Care
Medical Administrative Reviews
P.O. Box 62429
Virginia Beach, VA 23466-2429

A decision is made by the CMO within 45 days from receipt of the request for an Administrative Review.

Administrative Law (Medicaid) and DCH (PeachCare) Hearings
Peach Care for Kids members do not have access to the Medicaid Administrative Law Hearing process. If a Peach Care for Kids member is dissatisfied with a Notice of Adverse Action issued through an Administrative Review, the member can request a review of the decision by the State Management Review Committee (level two) in writing to:

PeachCare for Kids
Two Peachtree Street, NW
Atlanta, GA 30303-3159

Medicaid members may request an Administrative Law Hearing if members are dissatisfied with the outcome of the Administrative Review process. Members must complete the Administrative Review process prior to filing a hearing request with the State and must request the hearing within 30 calendar days of receipt of the Administrative Review

Decision. Only the member or member's representative may request an Administrative Law Hearing. Requests for Administrative Law Hearings may be made in writing to:

Department of Community Health Legal Services
General Council's Office
Two Peachtree Street, NW-40th Floor
Atlanta, GA 30303-3159

Grievances

Members may submit grievances to their Health Plan telephonically or in writing on any Georgia Families program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: access to dental care services, provider care and treatment, or administrative issues. Member complaints should be directed to:

Amerigroup Community Care
Attn: Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

A response to member complaints will be supplied immediately if possible but within no more than 90 calendar days from the date the grievance is received.

Note: Copies of DentaQuest policies and procedure can be requested by contacting Customer Service at 800.516.0124. (Policies 200.010, 200.011, 200.013, 200.017C, 200.019) or via e-mail at: denclaims@dentaquest.com

7.00 Utilization Management Program (Policies 500 Series)

7.01 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. 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.

7.02 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.

7.03 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.

7.04 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.

7.05 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.

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.

7.06 Peer to Peer Review Process

Providers may request a peer to peer with a DentaQuest dental consultant to discuss a determination regarding a clinical denial. Peer to peer requests are only completed with the treating dentist or an affiliated dentist. Prior authorization requests and claims do not qualify for a peer to peer if they are:

- System denials
- Contractual denials
- Administrative questions
- Approvals
- Denials due to eligibility
- Appeal requests related to a Complaints & Grievances case.

To request a peer to peer, the Provider must contact DentaQuest's customer service department at 800-516-0124. The Provider must provide the Customer Service representative with three date and time options that are within 48 hours of when the call to Customer Service was placed. Once a peer to peer call has been completed on an authorization/claim, another one cannot be requested on that same authorization/claim.

8.00 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 Customer Service Department at 800.516.0124 or via e-mail at denclaims@dentaquest.com.

9.00 Credentialing (Policies 300 Series)

DentaQuest, in conjunction with DCH and the CVO 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.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry.

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

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

Appeal of Credentialing Committee Recommendations. (Policy 300.017)

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

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

Discipline of Providers (Policy 300.019)

Disciplinary action may be initiated by any information the Committee deems appropriate for the welfare of a Member, DentaQuest or the Client. In making recommendations, the Credentialing Committee may consider quality of care, or any other factors it deems relevant.

Discipline may be recommended as a result of substandard performance, failure to comply with the administrative requirement set forth, or the professional criteria set forth, or any other reason deemed appropriate.

When there is a recommendation of termination it is presented to and approved by the Executive Subcommittee.

Procedures for Discipline and Termination (Policies 300.017-300.021)

The provider will receive written notice, through certified mail, of the discipline and/or termination. The written notification included the effective date of the disciplinary action or termination; a summary of the basis for the recommendation; the Provider's right to request an appeal of the recommendation; the time limit within which to request such an appeal; and a general description of the appeals process.

It is the responsibility of the Plan to report any terminations for quality of care issues to the appropriate licensing and/or regulatory agencies as required by law.

Recredentialing (Policy 300.016)

Network Providers are recredentialed at least every 24 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800.516.0124 or via e-mail at denelig.benefits@dentaquest.com.

10.00 The Patient Record

A. Organization

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

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

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

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

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

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

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

B. Content – The patient record must contain the following:

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

    a. Patient’s first and last name.
    b. Date of birth.
    c. Sex.
    d. Address.
    e. Telephone number.
    f. Name and telephone number of the person to contact in case of emergency.

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

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

g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

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

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

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

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

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

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

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

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

7. Radiographs which are:

   a. Identified by patient name.
   b. Dated.
   c. Designated by patient's left and right side.
   d. Mounted (if intraoral films).

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

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

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

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

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

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

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

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

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

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

    a. Date of service/procedure.
    b. Description of service, procedure and observation. Documentation in treatment record 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 by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation. (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service.

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

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

C. Compliance

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

11.00 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 enrollee 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.

12.00 Radiology Requirements

Accordingly, DentaQuest will be implementing a process for radiograph scanning which will improve timeliness in the claim review and decision process. To ensure proper scanning, effective May 21, 2012 **we will require radiographs be mounted when there are 5 or more radiographs submitted at one time.** Effective May 21, 2012, if 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claim will not be processed.

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.

Effective May 21, 2012, you will have the following options for submitting radiographs to us:

- Electronic submission using the new web portal.
- Electronic submission using National Electronic Attachment (NEA). For more information, please visit www.nea-fast.com and click the “Learn More” button.
- 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.

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

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.

13.00 Health Guidelines – Ages 0-18 Years

NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)

Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

14.00 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, 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 authorization 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.

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

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

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

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries

present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

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

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.
- In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
- Extractions performed as part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.

Authorization for Extraction of Impacted Third Molars:

- Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, and D7240.
- The prophylactic removal of disease-free third molars is not a covered benefit.

- Impacted third molars that do not show radiographic evidence of complete root formation will not qualify for an authorization for extraction.
- Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
- Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
- Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
- Lack of eruptive space will not qualify for an authorization for extractions of impacted third molars.

14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing 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.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs clearly showing the adjacent and opposing 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 authorization is not possible, will still require that appropriate radiographs clearly showing 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.

Authorizations 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.

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.

14.04 Criteria for Stainless Steel Crowns

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

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

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

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.
- Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and/or two or more cusps.
- Permanent bicuspid teeth should have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

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

- Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.

- Primary molars should have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

- Primary teeth that have had a pulpotomy or pulpectomy performed.

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

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

- Claim should include a dated post-endodontic radiograph.

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

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

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

- The patient must be free from active and advanced periodontal disease.

- The permanent tooth must be at least 50% supported in bone.

- Stainless steel crowns on permanent teeth are expected to last five years.

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

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.

- Tooth has advanced periodontal disease.

- Member is age 6 or older and tooth is a primary tooth with exfoliation imminent.

- Crowns are being planned to alter vertical dimension.

- Tooth has no apparent pathologic destruction due to caries or trauma.

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

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

Providers must submit the following documents for review by DentaQuest for authorization 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 an authorization may serve as a treatment plan.
- A completed Hospital IV/Sedation Member Referral Evaluation Tool (located in Appendix A; A-8).
- Narrative describing medical necessity for OR.
- Date of Service.
- Location of Service.

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

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

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

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

Criteria

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

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

- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).*

- Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during extensive dental procedures.*

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.*

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

- 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 authorization request.**

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.

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

- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing 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.

- 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.

Authorizations 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 that time has elapsed:
    - Adjustments will be reimbursed at one per calendar year per denture.
    - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
    - Relines will be reimbursed once per denture every 36 months.
    - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been

presented that all procedures to render the denture serviceable have been exhausted.

  - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.

- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

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

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization 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.

14.08 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.

14.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.

- Treatment plan.

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

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

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

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

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

  1) Radiographic evidence of root surface calculus.
  2) Radiographic evidence of noticeable loss of bone support.

14.11 Criteria for Medical Immobilization* Including Papoose Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient’s record should include:

- informed consent;
- type of immobilization used;
- indication for immobilization;
- the duration of application.

Indications*:

- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to lack of maturity;
- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to a mental or physical disability;

- when the safety of the patient and/ or practitioner would be at risk without the protective use of immobilization.

Contraindications*:

- cooperative patient;
- patient who cannot be immobilized safely due to associated medical conditions.

Goals of Behavior Management*:

- establish communication;
- alleviate fear and anxiety;
- deliver quality dental care;
- build a trusting relationship between dentist and child;
- and, promote the child's positive attitude towards oral/ dental health.

1. <u>Routine</u> **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.**

2. **Dentists should not restrain children without formal training at a dental school or approved residency program.**

3. **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**

4. **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

15.00 DentaQuest Georgia Dental Advisory Committee

Goals and Objectives

The DentaQuest of Georgia, LLC (DentaQuest) Georgia Dental Advisory Committee will work to cultivate better understanding between the dentists of the Georgia Medicaid Program and DentaQuest. The Committee shall be aware of DentaQuest's goals and limitations and utilize them to improve the partnership between the oral health community, the provider network, and DentaQuest. The goal of this partnership is to evaluate, improve and deliver the best possible oral healthcare to the Medicaid/PeachCare recipients in Georgia.

The Objectives of the Committee are:

- Advise when possible in the areas of policy development
- Help administer cost effective quality of care, by better understanding the processes used
- Work as liaisons with the provider network in order to foster cooperation with providers, such that a high standard of quality care for dental recipients in GA may be maintained.
- Set goals which are achievable based on the current economic status.
- Advise DentaQuest of areas of dental needs or concerns that may arise.
- Evaluate provider concerns that are gathered by the Care Maintenance Organizations questionnaires. Work as a group toward helping alleviate said concerns and problems.
- Achieve a better understanding of the process of Fraud and Abuse as it is reviewed in GA.
- Other projects as deemed appropriate by DentaQuest and/or the committee

Committee Composition:

Committee consists of DentaQuest staff members, a representative of the Georgia Dental Association and the Georgia Dental Society, and dentists contracted who participate in the Georgia Medicaid Program. Committee members are not held to term limitations and are able to participate for the duration of their choice. This is a voluntary program and committee members are not compensated for their participation.

16.00 Dental Home

The Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. For both the Georgia Families and the Georgia Families 360° programs, Dental Homes will be built from coordinated efforts of you the provider, the Amerigroup Care Coordination Team, and DentaQuest. Together we will establish a relationship with each member to ensure they are receiving proper oral healthcare and attending regular dental visits.

Oral health is integral to the healthy physical, social-emotional and intellectual development of every child and adult. For the special populations in the Georgia Families 360° dental program (Foster Care, Adoption Assistance, and the Department of Juvenile Justice), building a strong oral health foundation is all the more critical. Individuals in a Dental Home are more likely to receive appropriate and routine oral health care, thereby reducing the risk of preventable dental/oral disease. By establishing Dental Homes for this membership, we are providing a key component to each child's health.

"Dental Home Rosters" are refreshed daily and can be found on the provider web portal. The roster will contain a detailed listing of every member who has chosen them as their PCD. Providers who have any questions on assignments are encouraged to call the DentaQuest Provider Services Call Center or contact the Amerigroup Care Coordination Team.

17.00 Care Coordination

Care Coordination ensures that Georgia Families 360° members receive needed services in a supportive, effective, efficient, timely and cost effective manner. Each member's Amerigroup Care Coordinator has the primary responsibility of ensuring the member's medical, behavioral, dental and overall health needs are met. DentaQuest will be providing daily reports and updates to ensure the Amerigroup Care Coordination Team has up to date information about the member's dental services. The Amerigroup Care Coordination Team will reach out to educate members, foster parents and adoptive parents about the service needs of the members.

The Amerigroup Care Coordinator will reach out to the primary care physician assigned to their charge, within 10 days of the member becoming eligible, to schedule the member's first health screening. A dental screening will be included in this initial appointment. Subsequently, the Amerigroup Care Coordinator will schedule the member's first dental appointment within 30 days of the screening to address any dental needs identified. The appointments scheduled by the Amerigroup Care Coordination Team (and My Health Direct) should be billed through DentaQuest, using the processes you are accustomed to.

Please remember, not all appointments will be scheduled by the Amerigroup Care Coordination Team. The member's guardian or the member his- or herself may schedule appointments as well.

The member's caregiver is responsible for signing the patients' medical history and financial responsibility paperwork.

There are three subgroups of members in Georgia Families 360°: those in the custody of the Department of Foster Care Services (DFCS), those who are overseen by the Department of Juvenile Justice (DJJ) and those who receive Adoption Assistance (AA). These members' guardians are defined as follows:

1. (DJJ) Department of Juvenile Justice- Biological Parent and/or DJJ Case Worker
2. (AA) Adoption Assistance- Adoptive Parent
3. (DFCS) Department of Foster Care Services - DFCS Case Worker
4. (DJJ & FC joint custody) - Department of Juvenile Justice and DFCS Case Worker

Providers can contact the Amerigroup Care Coordination Team at 1-855-661-2021 regarding Georgia Families 360° members.

18.00 Primary Care Dentist Assignment

Primary Care Dentist (PCD)

A Primary Care dentist is a licensed dentist who is the health care provider responsible for supervising and coordinating the initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

As a PCD, your role will be to work with the Amerigroup Care Coordination Team and DentaQuest to provide a Dental Home for each member of this program and ensure they are receiving proper oral health care.

PCD Auto-Assignment

When DentaQuest is notified that a member is eligible for benefits, DentaQuest will assign a PCD to each member based upon the members' most recent dental visit or geographic access standards, if a PCD has not already been selected by the member his/her self.

PCD Self-Selection
Each member is encouraged to select a provider they wish to continue to visit as their PCD. To select a particular provider, members should follow the step-by-step instructions that have been made available through the Amerigroup member materials.

Through the member materials, they will be directed to visit the Member Web Portal to change or select a PCD. Members may also get assistance over the phone by calling the DentaQuest Member Services Call Center, and a representative will walk them through and assist them in selecting a PCD.

- DentaQuest.com
- DentaQuest Member Services Call Center – **800.895.2218**

PCD Assignment Requests by Non-Members
Any legal guardian and/or Amerigroup Care Coordinator who wishes to assign a PCD on a member’s behalf, can do so through accessing the Member Web Portal or calling into the DentaQuest Member Services Call Center.

When a parent or guardian calls into the DentaQuest Member Services Call Center, a representative will verify a unique identifier in addition to other HIPAA compliance standards. This identifier will allow our representative to assist them in selecting a new PCD.

PCD Assignment Notification
Once a PCD has been auto-assigned, a PCD Assignment letter will be generated in the Enterprise System. These letters will be sent to the Adoption Assistance members, indicating the assignment and providing the details for contacting the PCD.

PCD assignments, and any subsequent changes, will be indicated on a daily report that will be distributed to Amerigroup Care Coordination Team. All members will have access to their PCD assignment information via the DentaQuest Member Web Portal and Member Services phone line. The following Amerigroup member materials will direct them to this site:

- The Amerigroup Member Website
- The Amerigroup Member Handbook
- The Amerigroup Member Welcome Packet

PCD Termination Notification
Should a provider term with the dental program, a PCD Termination letter will be generated is generated and delivered to members in the Adoption Assistance and standard Medicaid programs 30 days in advance of the provider’s termination. These members will be instructed to select a new PCD.

At this point, the member would have two days to select a new PCD, either through the DentaQuest Member Web Portal or by calling the Member Services Call Center. If in two days the member has not selected a PCD, DentaQuest will auto-assign a new PCD within five days and send the PCD Assignment letter.

APPENDIX A - ATTACHMENTS

General Definitions

The following definitions apply to this Office Reference Manual:

A. "DCH" means Georgia Department of Community Health

B. "Contract" means the document specifying the services provided by DentaQuest to:

- an employer, directly or on behalf of the State of Missouri, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Georgia or its regulatory agencies or Plan and DentaQuest (a "Medicaid Contract");
- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

C. "Covered Services" is a dental service or supply that satisfies all of the following criteria:

- provided or arranged by a Participating Provider to a Member;
- authorized by DentaQuest in accordance with the Plan Certificate; and
- submitted to DentaQuest according to DentaQuest's filing requirements.

D. "DentaQuest" shall refer to DentaQuest of Georgia, LLC

E. "DentaQuest Service Area" shall be defined as the State of Georgia.

F. "Medically Necessary:" It is the responsibility of the health plan to determine whether or not a service(s) furnished or proposed to be furnished is (are) reasonable and medically necessary for the diagnosis or treatment of illness or injury, to improve the function of a malformed body member, or to minimize the progression of disability, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered; and service(s) could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting.

G. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

H. "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.

I. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.

J. "Plan Certificate" means the document that outlines the benefits available to Members.

K. "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.

L. "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.

New Appointment Guidelines

1) Patient Appointments; 2) Patient Wait Times; 3) After-Hours Phone Call Response Times

Patient Appointments for Standard Medicaid:

Routine appointments must be made available within 21 days of request by the patient.

Emergency appointments must be made available within 48 hours of request from patient.

Patient Appointments for Georgia Families 360˚$_{SM}$:

Routine appointments must be made available within 10 days of request by the patient.

Urgent appointments must be made available within 48 hours of request by the patient.

Emergency appointments must be made available within 24 hours of request from patient.

Patient In-Office Wait Times:

Scheduled appointments - Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Work-in or Walk-in - Waiting times shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Patient After Hours Phone Calls:

Urgent - provider should return call within 20 minutes.

All other calls - provider should return call within 1 hour.

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. Once you have entered the website, click on “LOGIN”. From there choose “Dentists” under Medicare/Medicaid. You will then be able to log in using your password and User ID. Once logged in, select the link “Related Documents” to access the following resources:

- Orthodontic Services
- Orthodontic Criteria Index Form Georgia
- OrthoCAD Submission Form
- Orthodontic Continuation of Care Form
- Dental Claim Form
- Instructions for Dental Claim Form
- Non – Covered Services Disclosures Form
- Provider Appeal Form
- Member Consent Form
- Hospital IV/Sedation Member Referral Evaluation Tool
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit
- Medical and Dental History
- Coverage Exception Request Form
- Provider Change Form
- Request for Transfer of Records

These forms may also be found within this manual.

Orthodontic Services For Members Ages 0-20

Recipients with Medical Assistance, ages 0-20, who access their Early and Periodic Screening, Diagnosis and Treatment Program, (EPSDT) benefit may qualify for orthodontic care under the program, if medically necessary. Recipients must have a severe, dysfunctional, handicapping malocclusion. Any Medical Assistance recipient aged 0-20, who has had an appointment with a dentist, is considered to be an EPSDT participant and therefore eligible for orthodontics if medically necessary.

Since a case must be dysfunctional to be accepted for treatment, recipients whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually functional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. Orthodontic **services are only considered for those recipients with permanent dentitions.** The recipient should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing. (Cleft palate cases and unusual oral-facial anomalies may receive special consideration for treatment during the transitional dentition).

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the recipient's mouth. The recipient must be eligible on this date of service.

Photographs, full mouth radiographs or panorex must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. **Dentists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the patient; or face termination of their Provider Agreement.**

DentaQuest will utilize The "Ortho Criteria Index Form" (copy on following page) presently used to determine the presence of a handicapping malocclusion. A copy of the scoring sheet DentaQuest uses can be found on pages

Payment for orthodontics includes all appliances and all follow-up visits. Providers cannot bill for the replacement of removable orthodontic appliances and post-treatment maintenance retainers that are lost or damaged

If the case is denied, the prior authorization will be returned to the Provider indicating that the orthodontic treatment will not be covered by DentaQuest. However, an authorization will be issued for the payment of the radiographs and diagnostic models at a rate of $83.53.

First Review ___

___ Second Review ___

___

Rays

___

___

Models

Orthocad

Ceph Films ___
X-

___ Photos

Narrative

DENTAQUEST
ORTHODONTIC CRITERIA INDEX FORM GEORGIA – COMPREHENSIVE D8080

Patient Name: ______________________________ DOB:___________

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
AX	Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
OJ	Overjet in excess of 9 mm.		
NO	Negative Overjet greater than 3.5mm.		
LL	Cleft Lip/Palate deformities and other significant craniofacial anomalies.		
FAS	Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.		

APPROVED: ☐ **DENIED:** ☐

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS

Richard Nellen, DDS   Paul Schulze, DDS

OrthoCAD Submission Form

Date:___________________

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

Treatment Requested	
Code:	**Description of request:**

Continuation of Care Submission Form

Date:___________________

Patient Information

Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information

Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:

Name of Previous Vendor that issued original approval:

Banding Date: **Case Rate Approved By Previous Vendor:**

Amount Paid for Dates of Service That Occurred Prior to DentaQuest:

Amount Owed for Dates of Service That Occurred Prior to DentaQuest:

Balance Expected for Future Dates of Service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

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

Mail to:
DentaQuest, LLC
Attn: Continuation
12121 N. Corporate Parkway
Mequon, WI 53092

Hospital / IV Sedation Member Referral Evaluation Tool

Member Name: ______________________

ID Number: ______________________

Provider Name: ______________________

Factors:

Age:	
Age:	**Points** (Circle choice)
0 - 3 yrs	7
4 - 5 yrs	5
6 - 7 yrs	3
8 - 9 yrs	1
10 + yrs	0

Health Complications (Documented with MD Letter)	
Medically compromised/handicapping condition	**Points** (Circle choice)
History of Uncontrolled Bleeding	13
Cerebral Palsy	13
Asthma/Breathing Problems	9
Autism/ADHD	8
Heart/Blood Pressure Problems	8
Moderate Retardation	8
Mild Retardation	6
Anxiety (situational)	5

Services required (total # of teeth restored and extractions)	
	Points (Circle choice)
Services - 13 +	10
Services - 10 - 12	9
Services - 7 - 9	7
Services - 4 - 6	5

Documentation of medical necessity- *REQUIRED*	
Clinical notes from dentist demonstrating failed trial for dental services in dental office setting.	5

Total Score:	
Eligible for outpatient hospital procedure	**15 points or more**
Signature of DQ Dentist authorizing outpatient hospital dental service approval:	

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐M ☐F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 ☐Self ☐Spouse ☐Dependent ☐Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐M ☐F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐Self ☐Spouse ☐Dependent Child ☐Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐M ☐F

23. Patient ID/Account # (Assigned by Dentist)

fold

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A___ B___ C___ D___

31a. Other Fee(s)

32. Total Fee $0.00

fold

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefi plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X____________________
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X____________________
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐No (Skip 41-42) ☐Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis ☐No ☐Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐Occupational illness/injury ☐Auto accident ☐Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X____________________
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number

58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

General Instructions

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

Coordination of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

National Provider Identifier (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

Additional Provider Identifier

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

Provider Specialty Codes

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

Non-Covered Service Disclosure Form

The Member may purchase additional services as a non-covered procedure/s or treatment/s for an additional charge. DentaQuest requires that you and the member complete the **Non-Covered Services Disclosure Form** prior to rendering these services. A copy of this form must be kept in the Member's treatment record. If the Member elects to receive the non-covered procedure/s or treatment/s the member would pay a fee not to exceed the maximum rate of your usual and customary fees as payment in full for the agreed procedure/s or treatment/s.

The Member is financially responsible for such services. If the Member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the Member's treatment record. Failure to comply with this procedure will subject the provider to sanctions up to and including termination.

Non – Covered Services Disclosures Form

This section to be completed by dentist rendering care

I am recommending that ____ receive
(Member Name and Medicaid Number)
services that are **not** covered by the DentaQuest Covered Benefits and Fee Schedule. The following procedure codes are recommended: FEES NOT TO EXCEED PROVIDER'S UCF (usual and customary fee).

Code	Description	Fees

The total amount for service(s) to be rendered is $_______________.

____
Doctor's Signature Date

This section to be completed by member

I ____, have been told that I require
(Print Name)
services or have requested services that are not covered by the DentaQuest Covered Benefits and Fee Schedule.

Read the following questions and check either Yes or No:

Question	Yes	No
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by Medicaid/PeachCare.		
I am aware that I am financially responsible for paying for these services.		
I am aware that Medicaid/PeachCare is not paying for these services.		

I agree to pay $_______________ per month. **If I fail to make this payment I may be subject to collection action.**

____
Patient's Signature if over 18 or Parent or Guardian Date

COVERAGE EXCEPTION REQUEST FORM

Member Name	Medicaid ID No.	DOB

Provider Name	Provider ID No.	Location Name & Address

☑	Code	Description	Documentation Required
☐	D0150	Comprehensive Oral Evaluation	If submitted by same dentist or group, narrative description of established patient's significant change in health conditions or unusual circumstances.
☐	D0210	Intraoral - Complete Series	Narrative of medical necessity for complete series radiographs under age 6.
☐	D0272	Bitwings - Two Films	Narrative of medical necessity for two bitewing films under age 2.
☐	D0274	Bitewings - Four Films	Narrative of medical necessity for four bitewing films under age 10.
☐	D0330	Panoramic Film	Narrative of medical necessity for panoramic film under age 6.
☐	D1203	Topical Application of Fluoride - Child	Narrative confirming existence of primary dentition for patient over age 13 and dated radiograph showing at least one retained deciduous tooth.

Narrative

Signature of Treating Dentist	Date

Current Dental Terminology © 2009 American Dental Association. All rights reserved.

DentaQuest Provider Appeal Form

DentaQuest
Attn: Complaints & Grievances
PO Box 2906
Milwaukee, WI 53201-2906

Member Name: ____

Member Identification Number: _____________________________________

Date of Service: ____

Date EOB was received: ____

Authorization Number: ____

Date Authorization was received: ____________________________________

Provider Name: ____

Location Number: ____

Office Contact: ____

Office Phone Number: ____

Reason for Appeal:

____
____
____
____
____
____

Outcome office is requesting:

____
____
____

Consent for Provider to File Appeal

For a provider to file an appeal for a member, the member must give their written consent. The consent can be in any form as long as it contains the following: specifics of the service being appeals, such as the type of service, date of service, provider of the service; member's name; member's signature; date of signature. Below if a sample consent form.

CONSENT

I, ___________________ (Member Name), give _____________________(Provider Name) permission to appeal on my behalf the following action:
Denial of orthodontics (braces)

_______________________________________ ________________________
Member Signature Date

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME ______________________________
Last First Middle

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B
L

A B C D E F G H I J

RIGHT LEFT

T S R Q P O N M L K

L
B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

RECALL EXAMINATION

PATIENT'S NAME____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY ___________________________
____

	OK		OK
LYMPH NODES		TMJ	
PHARYNX		TONGUE	
TONSILS		VESTIBULES	
SOFT PALATE		BUCCAL MUCOSA	
HARD PALATE		GINGIVA	
FLOOR OF MOUTH		PROSTHESIS	
LIPS		PERIO EXAM	
SKIN		ORAL HYGIENE	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS:____
____
____

RECALL EXAMINATION

PATIENT'S NAME____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY ___________________________
____

	OK		OK
LYMPH NODES		TMJ	
PHARYNX		TONGUE	
TONSILS		VESTIBULES	
SOFT PALATE		BUCCAL MUCOSA	
HARD PALATE		GINGIVA	
FLOOR OF MOUTH		PROSTHESIS	
LIPS		PERIO EXAM	
SKIN		ORAL HYGIENE	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS:____
____

NOTE: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Authorization for Dental Treatment

I hereby authorize Dr. ___________________________ and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): ____

Tooth Number(s): ____

Date: _____________________________________

Dentist: __________________________________

Patient Name: ______________________________

Legal Guardian/
Patient Signature: ____________________________

Witness: __________________________________

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST OF GEORGIA, LLC

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT:** Attach voided check from checking account.

MAINTENANCE TYPE:

__________ Add
__________ Change (Existing Set Up)
__________ Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: ____

Account Type: __________ Checking

__________ Personal __________ Business (choose one)

Bank Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Bank Name: ____

Account Holder Name: ____

Effective Start Date: ____

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest of Georgia, LLC** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

___________________________________ ____
Date Print Name

_______________________________________ ____
Phone Number Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

____
Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

____
Tax Id (As appears on W-9 submitted to DentaQuest)

MEDICAL AND DENTAL HISTORY

Patient Name: ______________________________ Date of Birth: __________________

Address: ____

Why are you here today? ____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? ____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: ____

Address: ____

Telephone: ____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: ______________________________________

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: ____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? ____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? ____________________________________

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: ____

Indicate which of the following you have had, or have at present. Circle “Yes” or “No” for each item.

Heart Disease or Attack	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Arteriosclerosis (hardening of arteries)	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Cold sores/Fever blisters/ Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cortisone Medication	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cosmetic Surgery	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No			
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No			

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? ____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: ______________________ Date: ____________________

Dentist’s Signature: ______________________ Date: ____________________

Review Date	Changes in Health Status	Patient’s signature	Dentist’s signature

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077

Section 1: Current Information - *Complete for ALL Requests - Asterisk denotes required fields*

Change Effective Date *(Required)*:

*Provider Last Name | *Provider First Name

*Individual National Provider Identifier (NPI) #

Date of Birth | Social Security # | Gender

*Specialty | *Personal E-Mail

Requestor Information

*Requestor Name | *Title

*Requestor Contact Information *(Phone or E-mail)*

Section 2: Type of Update - Check all that Apply - *Complete for ALL Requests* - For Questions contact your Provider Engagement Representative or Customer Service

- ☐ Business (Tax ID) - Add/ Term/ Update - **Complete Sections 1, 7 and 8**
- ☐ Credentialing Correspondence Change/Update - **Complete Sections 1 and 5**
- ☐ EFT/ Payment - **Complete Sections 1 and 8**
- ☐ License Change - **Complete Sections 1 and 4**
- ☐ Name Change - **Complete Sections 1 and 3**
- ☐ Location - Add/ Term/ Update - **Complete Sections 1 and 6**
- ☐ Termination Request - **Complete Sections 1 and 9**

Section 3: Name Change - *Attach supporting legal documentation*

New Last Name | New First Name

New Middle Name | New Suffix

Please Note: Before DentaQuest can change your name in our system, your license must reflect the name change.

Section 4: License Change

New Dental License Number | State

New DEA License Number | State

New State Drug License Number | State

New Medicaid License Number | State

Other License Name

Other License Number | State

Section 5: Credentialing Correspondence Change

Credentialing Contact Name

Correspondence Address

City | State | Zip Code

Telephone | Fax

Credentialing E-Mail

Provider Update Form - Provider Operations

Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add ☐ Term ☐ Update

Tax ID Number ______ Medicaid ID (if applicable) ______

Location Name ______

Location Address ______

City ______ State ______ Zip Code ______

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone ______ Fax ______

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail ______

Office Hours Monday - ______ Tuesday - ______

Wednesday - ______ Thursday - ______

Friday - ______ Saturday - ______

Sunday - ______ Ages Minimum ______ Ages Maximum ______

☐ Primary Location ☐ Handicapped Accessible

Office Languages ______

Section 7: Business - (Tax ID) Add/ Term/ Update - *Updated Contract, W9 and Disclosure of Ownership required for all Adds and Updates - W9 and Disclosure of Ownership Attached*

☐ Add ☐ Term ☐ Update

Old/ Current Tax ID Number ______ New Tax ID Number ______

Business Name ______

Business Address ______

City ______ State ______ Zip Code ______

Telephone ______ Fax ______

Office E-Mail ______

Group NPI ______

Please Note: DentaQuest requires a Group NPI for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?
If yes, please provide a date of when all claims will be submitted by: _______________ ☐ Yes ☐ No

Section 8: EFT/ Payment

Tax ID Number ______

Payment Address ______

City ______ State ______ Zip Code ______

☐ Add EFT ☐ Cancel EFT ☐ Change EFT

Please Note: The DentaQuest EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached)

Provider Update Form - Provider Operations

Section 9: Termination Request

☐ Term Provider at Location Listed Below	Tax ID Number	

Please attach document with any additional locations to be termed.

☐ Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐ Term Business	Tax ID Number	

Please attach a list of providers and locations that need to be terminated.

Term Reason/ Comments

Location Name

Location Address

City | State | Zip Code

Section 10: Type of Update - Check all that Apply - ***Complete for ALL Requests - Internal Use ONLY***

- ☐ Product(s) Add/ Update/ Term- **Complete Sections 1, 10 and Notes**
- ☐ Claims Issue(s) - **Complete Sections 1, 10 and Notes**
- ☐ Dental Home - **Complete Sections 1, 10 and Notes**
- ☐ Fee Schedule Add - **Complete Sections 1, 10 and Notes**
- ☐ Fee Schedule Change - **Complete Sections 1, 10 and Notes**
- ☐ Provider Rule Add - **Complete Sections 1, 10 and Notes**
- ☐ Provider Rule Change - **Complete Sections 1, 10 and Notes**

Notes

Provider Update Form - Provider Operations

Additional Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add ☐ Term ☐ Update

Tax ID Number ______ Medicaid ID (if applicable) ______

Location Name ______

Location Address ______

City ______ State ______ Zip Code ______

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone ______ Fax ______

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail ______

Office Hours

Monday -	Tuesday -
Wednesday -	Thursday -
Friday -	Saturday -
Sunday -	

Ages Minimum ______ Ages Maximum ______

☐ Primary Location ☐ Handicapped Accessible

Office Languages ______

Request for Transfer of Records

I, ____________________________, hereby request and give my permission to Dr. ________________________ to provide Dr.__________________________________ any and all information regarding past dental care for _____________________________.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

____

____

____

Signed: _________________________________ Date: ________________________
(Patient)

Signed: _________________________________ Date: ________________________
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: ____

Address: ____

Phone: ____

APPENDIX B

Covered Benefits (See Exhibits A – J)

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 Customer Service department directly at:**

800.516.0124, 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. 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).

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 A - J) 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,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

DentaQuest Authorization Process

IMPORTANT

For procedures where "Authorization Required" fields indicate "**yes**".

Please review the information below on when to submit documentation to DentaQuest. The information refers to the "Documentation Required" field in the Benefits Covered section (Exhibits A - J). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completion of treatment.

When documentation is requested:

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation Requested	Emergency	Send documentation with claim after treatment

When documentation is requested "with claim:"

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment