Provider Office Reference Manual

TX Community First Health Plan, Inc.

STAR+PLUS,
STAR+PLUS Waiver,
STAR+PLUS Waiver MMP

Service Areas: Bexar

11100 W. Liberty Drive
Milwaukee, WI 53224
888-308-9345
www.dentaquest.com

DentaQuest USA Insurance Company, Inc.
Address and Quick Reference Telephone Numbers

DentaQuest Provider Services:
888.308.9345

DentaQuest Member Services:
800.436.5286

TTY Service:
711

Claims Questions:
txclaims@dentaquest.com

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

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1.800.436.6184
- Visit https://oig.hhsc.state.tx.us and pick "Click Here to Report Waste, Abuse and Fraud" to complete the online form or

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

Credentialing applications should be sent to:
DentaQuest- Credentialing PO
Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

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

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

Fax numbers:
Claims/Payment Issues: 262.241.7379
Claims to be processed: 262.834.3589
All other: 262.834.3450

1.00 Introduction

1.01 Program Background

DentaQuest USA Insurance Company, Inc. (DentaQuest) administers the Medicaid Home and Community-Based Services (HCBS) STAR+PLUS Waiver, STAR, STAR+PLUS, STAR+PLUS MMP (Medicare-Medicaid), Medicare Advantage & D-SNP. No other dental benefits administrator has the amount of experience, the level of clinical expertise, or the range of technology possessed by DentaQuest USA. We employ these tools to promote an efficient dental program that will give Medicaid members of Texas the best chance to achieve a bright oral health future.

STAR+PLUS is a Texas Medicaid managed care program for eligible people who have physical or mental disabilities or who are elderly. Most adults on supplemental security income (SSI) will be required to enroll in STAR+PLUS if the program is offered in the area of the State where they live. SSI children may choose to enroll in STAR+PLUS or may remain in traditional Medicaid.

1.02 Program Objectives

The primary objective of Community First and DentaQuest is to create a supplemental set of benefits for HCBS STAR+PLUS Waiver members, by offering quality dental services to those eligible Texas residents. We emphasize early intervention and promote access to care, thereby improving health outcomes for Texas residents.

2.00 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 888-308-9345.

3.00 Credentialing (Policies 300 Series)

DentaQuest, in conjunction with Community First Healthcare, 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 Program.

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.

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 calendar days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 36 months in accordance with NCQA guidelines.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service department at 888-308-9345.

4.00 The Patient Record

4.01 Organization

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

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

2. The design of the record must provide the capability of 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.

4.02 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. 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. Adequate update of health history at subsequent recall examinations which requires documentation of these items:

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

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

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

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

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

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

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

7. Radiographs which are:

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

8. 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. 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. 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. 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.

4.03 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.

5.00 Patient Recall System Requirements

5.01 Recall System Requirement

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

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."

- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. A Medicaid member cannot be charged for a missed appointment. 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.

6.00 Utilization Management Program (Policies 500 series)

6.01 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.

6.02 Community Practice Patterns

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

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

6.03 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.

6.04 Results

With the objective of ensuring the fair and appropriate distribution of these budgeted Medicaid 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.

7.00 Provider Responsibilities

7.01 Office Compliance Verification Procedures

In conjunction with its office claim audits described, DentaQuest will measure compliance with the requirement to maintain a patient recall system.

DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability. Dental appointments are to be made during normal business hours and within a reasonable time from the date of the member's request. Appointment Standards are:

- Routine- 30 calendar days
- Therapeutic/diagnostic- 14 calendar days
- Urgent- 24 hours

Emergency dental services are limited to the following:

- Procedures necessary to control bleeding, relieve pain, and eliminate acute infection;
- Operative procedures required to prevent imminent loss of teeth; and
- Treatment of injuries to the teeth and supporting structures.

Routine restorative procedures and root canal therapy are not emergency services. Emergency services must be justified with documentation. The dentist's narrative documentation should describe the nature of the emergency, including relevant clinical information about the patient's condition and stating why the emergency services rendered were considered to be immediately necessary.

Routine dental services include diagnostic and preventive visits. Therapeutic services are those such as fillings, crowns, root canals and/or extractions.

7.02 Emergency Dental Services

DentaQuest is not responsible for coverage or payment of Non-Capitated Services, including emergency dental services provided to Members in a hospital or ambulatory surgical center setting. DentaQuest will educate Members and Providers about the availability of, and how to access, Non-Capitated emergency dental services. DentaQuest must refer Members to Non-Capitated Service providers and provide coordination of care for Non-Capitated Services. This coordination of care must include:

- identifying providers of Medically Necessary dental services; and
- helping the Member access needed Medically Necessary dental services to the extent they are available to the member.

DentaQuest is responsible for informing Providers that bills for all Non-Capitated Services must be submitted to Community First or HHSC's Claims Administrator, as appropriate.

EMERGENCY Treatments and Authorizations

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

Please FAX this to 262-241-7150

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

7.03 Standard of Care

All covered dental services shall be provided according to generally accepted standards of dentistry prevailing in the professional community at the time of treatment. Contracting dentists are required to integrate specialty care into the

Member's course of dental treatment by making timely referrals to a specialist when necessary or appropriate. Specialty providers are responsible for providing the appropriate care to Members who have been referred. Contracting dentists may not impose any limitations on the acceptance or treatment of Community First Members not imposed on other patients. The dentist is required to maintain the dentist/patient relationship with the Community First Member and shall be solely responsible to the Member for dental advice and treatment.

7.04 Professional Conduct

While performing the services described in the Network Provider contract, the network Provider agrees to:

- Comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
- Otherwise conduct themselves in a businesslike and professional manner.

7.05 Provision of Services

Provider shall render to Members all Covered Services and continue to provide Covered Services to Members. After the date of termination from participation, upon the request of DentaQuest, Provider shall continue to provide Covered Services to Members for a period not to exceed ninety (90) days during which time payment will be made pursuant to the DentaQuest Provider Contract.

Please refer to the DentaQuest TX Provider Contract for more information regarding termination.

7.06 Provider Directory

DentaQuest publishes a provider directory to Members. The directory is updated periodically and includes: provider name, practice name (if applicable), office addresses(s), telephone number(s), provider specialty, panel status (for example, providers limiting their practice to existing patients only), office hours, and any other panel limitations that Community First is aware of, such as patient age minimum and maximum, etc.

It is very important that you notify DentaQuest of any change in your practice information. Please complete the Provider Change Form, fax it to DentaQuest at 262.241.4077 or call us at 888-308-9345 to report any changes.

7.07 Broken Appointments – Best Practices

Broken appointments are a concern for Community First and DentaQuest. We recognize that broken appointments are a costly and unnecessary expense for providers. Our goal is to remove any barriers that prevent dentists from participating in the program as well as barriers that prevent our Members from utilizing their benefits.

As a result of feedback we have received from dentists in the community, we have developed several Broken Appointment Best Practice guidelines. We encourage you to implement these practices in your office.

The following list contains office policies which have helped to reduce broken appointments and the effects of broken appointments in other dental practices.

- Confirm appointments after hours when the patient is likely to be home to answer the call.
- Confirm all appointments, including recall and hygiene appointments, the day

before the appointment.

- Consider telling patients they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- Continuing care appointments made for three to six months ahead should be reserved for patients of record with no history of broken appointments.
- Patients with a history of broken appointments or that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency patients will not keep future appointments if scheduled on the day of emergency treatment. These patients should be called later during the week to schedule follow-up treatment.
- When a procedure needs to be completed at a subsequent appointment, send information home with patients about that next appointment. The information should stress the importance of such a procedure and indicate possible outcomes if it is not completed within the designated timeframe.
- Maintain a list of patients that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many patients cite daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of the week or occasional weekend hours can alleviate this barrier to accessing dental care.

7.08 Logging Broken Appointments in the Provider Web Portal

Entering a Member's broken appointment is an easy alternative to faxing broken appointment information to DentaQuest. By using the Broken Appointment tool, providers and office staff can enter the date and reason for the broken appointments, or view a list of missed appointments.

The Broken Appointment page is comprised of 2 sections:

- Add Broken Appointment: This is where you add a member's broken (missed) appointment.
- Broken Appointment History: In this section, you can view a list of all missed appointments of a specific member.

7.09 Referrals to Specialists

Community First Members do not require authorization to see a dental specialist. However, only services provided by a Contracting Dentist are covered by DentaQuest, therefore an Community First Member must be treated by a dentist enrolled in DentaQuest. In the event it is necessary to refer a Member to a specialist for treatment, please be sure to refer the Member to a contracted DentaQuest dentist. You may look at the DentaQuest website to locate a dental specialist in the area.

Members with Special Health Care Needs may have direct access to Specialists as appropriate for the Member's condition and identified needs.

If you cannot locate a specialist in your area, you may call DentaQuest's Provider Call Center's toll-free telephone number to facilitate a Member referral to a Specialist.

7.10 Continuity of Care

Subject to compliance with applicable federal and state laws and professional standards regarding the confidentiality of dental records, participating dentists must assist DentaQuest in achieving continuity of care for Community First Members through the maximum sharing of Members' dental records. Within 30 days of a written request by a Member, you must be able to provide copies of the patient's

dental records to any other dentist treating such Member. This also applies when a Member moves out of the area. Community First Members are not subject to limitations or exclusions of covered dental benefits due to a pre-existing condition.

8.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy Standards as well. DentaQuest also intends to comply with all Administrative Simplification and Security Standards by their compliance dates. One aspect of our compliance plan will be working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has/will be modifying its provider contracts to reflect the appropriate HIPAA compliance language. The contractual updates include the following in regard to record handling and HIPAA requirements:

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

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

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT 2009-2010 codes listed in this manual. In addition, all paper claims must be submitted on a 2012 or later approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 888-308-9345 or via e-mail at denelig.benefits@dentaquest.com.

9.00 Second Opinion Reviews and Regional Screening

DentaQuest may request a clinical evaluation by a regional dental consultant who conducts clinical examinations, prepares objective reports of dental conditions and evaluates treatment that is proposed or has been provided for the purpose of providing DentaQuest with a second opinion.

A second opinion may be required prior to treatment when necessary to make a benefit determination. Authorization for second opinions after treatment can be made if a Member has a complaint regarding the quality of care provided. The Member and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is authorized through a regional dental consultant, all charges will be paid by DentaQuest.

Members may otherwise obtain a second opinion about treatment from any contracting dentist they choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the benefits of the program.

10.00 Out of Network (OON) Referrals

Out of network referrals are covered only if:

- The service is medically necessary and the covered service is not available through an in-network provider.
- The existing (in-network) provider requests that the work be done by an OON provider (referral).
- Reimbursement for Medicaid OON providers is 95% of the fee-for-service rate in effect on the date-of-service unless a different reimbursement amount is agreed upon.

Please contact Provider Services for assistance in locating an in-network provider.

11.00 Medicaid Member Transportation (Non-Emergency)

HHSC's Medical Transportation Program (MTP) is designed to serve Medicaid Members that have no other means of transportation for medical, behavioral, dental or vision appointments. MTP will utilize the most cost-effective method of transportation that does not endanger a patient's health.

A Member should contact the Texas Department of Health Medical Transportation Program (MTP) at 1-855-687-3255 for the Dallas/Fort Worth area, at 1-855-687-4786 for the Houston/Beaumont area, or at 1-877-633-8747 for all other areas to learn more or set up a ride. Members should call as soon as they know their next appointment date. MTP requires at least 48-hour notice for most requests. The Member should notify MTP if they have any type of special needs so MTP can send the right type of vehicle. For example, for people who use a wheelchair, MTP can send a van with a wheelchair ramp.

Members under the age of 18 may be required to travel with an adult. Transportation specialists are available to take requests weekdays 8:00 a.m. to 5:00 p.m. You can go to www.HHSC.state.tx.us and click on "Questions about your benefits?" for more information.

The MTP program may also reimburse mileage for the Member, a Caregiver/Medical consenter, friend or someone else to take the client to health care services; if the trip is scheduled in advance and the driver abides by the MTP guidelines.

12.00 Authorization for Treatment

12.01 Dental Treatment Requiring Authorization-Prior Authorization

Authorizations are utilization tools that require 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, and Community First harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to submit documentation for review after the service is rendered. Authorization can be made through prior approval or by prepayment review. Prior authorization is optional for all covered procedures with the exception of all Orthodontic codes (see Requirements identified in Exhibit A).

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. Please review these criteria as

well as the benefits covered (Exhibits) to understand the decision making process used to determine payment for services rendered.

Prior Authorization- Dental services or treatment locations that require review by DentaQuest for determination of medical necessity and approval before delivery are subject to prior authorization. Proper documentation must be submitted with requests for prior authorization.

Your submission of "documentation" should include:

1) Radiographs, narrative, or other information where requested (see Exhibits for specifics by code); and
2) CDT codes on the ADA claim form.

Your submission should be sent on a 2012 or later 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 prior authorization. The "Documentation Required" column will describe what information is necessary for review.

Utilization management decision making is based on appropriate care and service, and does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization. DentaQuest does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits.

12.02 Submitting Authorization or Claims with X-Rays

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

Please note we also require radiographs be mounted when there are 4 or more radiographs submitted at one time. If 4 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2012 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

It is important not to submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. **DentaQuest does not generally return x-rays and other**

supporting documentation. However, if you wish to have your x-rays returned, they must be submitted with a self-addressed stamped envelope.

12.03 Electronic Attachments

A. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests and claims submissions. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Enrolled 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 clearinghouses 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. Submissions using **OrthoCAD™ also** require the submission of the form found on page A-4. DentaQuest allows Enrolled 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.

13.00 Coordination of Non-Capitated Services

Medicaid Services Not Covered by DentaQuest

The following Texas Medicaid programs and services are paid for by HHSC's claims administrator instead of DentaQuest. Medicaid Members can get these services from Texas Medicaid providers.

1. Early Childhood Intervention (ECI) case management/service coordination;
2. DSHS case management for Children and Pregnant Women;
3. Texas School Health and Related Services (SHARS);
4. Health and Human Services Commission's Medical Transportation.

Either the member's medical plan or HHSC's claims administrator will pay for devices for craniofacial anomalies, and for emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (E.G., anesthesia and drugs for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin; and
- Treatment craniofacial anomalies.

If a member is in need of assistance in coordinating any non-capitated services, a Member Advocate may be contacted to assist. Please contact our Member or Provider Service Line and ask to be referred to a Member Advocate.

14.00 Coordination of Care – Outpatient Facilities and Hospitals

DentaQuest does not require Participating Providers to prior authorize dental services performed under general anesthesia. Should the Participating Provider want or need assistance in coordinating care with Community First, the Provider may contact DentaQuest Provider Services and request assistance from a Member Advocate. The Member Advocate will collect the prior authorization request with date and place of service indicated. DentaQuest will review the case for medical necessity and render an approval or denial of the planned treatment. Once DentaQuest has approved the case, a DentaQuest Member Advocate will coordinate authorization for non-dental services with Community First, as appropriate.

Coordination of all specialty care is the responsibility of the member's primary care provider. The primary care provider must be notified by the dentist or the MCO of the planned services. Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

15.00 Provider Complaints and Appeals Process

15.01 Provider Complaints

Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. If a complaint cannot be resolved within 30 days, the provider will be notified in writing the status of the complaint.

Complaints to DentaQuest may be submitted using the following methods:

(non-claim related) • By telephone at 888-308-9345

(Claim related) • In writing to:

DentaQuest
Complaints & Grievance
PO Box 2906
Milwaukee, WI
53201-2906

If a provider is not satisfied after completing the Provider Complaint Process or feels that they did not receive due process, providers may file a complaint with HHSC. A provider must exhaust the Provider Complaint Process before filing with HHSC.

Medicaid complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

Or e-mail complaint requests to:
HPM_Complaints@hhsc.state.tx.us

15.02 Provider Claim Appeals

For appealed claims, Providers must submit all appeals of denied claims and requests for adjustments on paid claims within **sixty (60) days** from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared. If you have questions regarding claims, please contact DentaQuest Provider Services at 888-308-9345.

16.00 Medicaid Member Complaint Process

Medicaid Member Complaint

A Medicaid complaint is an expression of dissatisfaction expressed by a member, orally or in writing to DentaQuest, about any matter other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us to tell us about your problem. A DentaQuest Member Services advocate can help you file a complaint. Just call 800-436-5286. Most of the time, we can help you right away or at the most within a few days. You can also send your complaint in writing to:

DentaQuest
Complaints and Grievances
P.O. Box 2906
Milwaukee, WI
53201-2906

How long will it take to process my complaint?
Once we receive your complaint, DentaQuest will acknowledge your complaint within five (5) business days or receipt. We will respond within thirty (30) calendar days of receipt of your complaint. The resolution letter will tell you what we have done to address your complaint.

How do I file a complaint with the Health and Human Services Commission if I am not satisfied with the outcome of my complaint?
Once you have gone through the DentaQuest complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989, 8 am – 5pm. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

Fax: 888-780-8099

If you can get on the Internet, you can submit your complaint at:
https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman- managed-care-help

17.00 Medicaid Member Appeal Process

17.01 Medicaid Member Appeals

A Medicaid Appeal is the formal process by which a Member or his or her representative can request a review of DentaQuest's Action.

If a member, or member's representative, disagrees with a decision made to deny a covered service, they have the right to appeal. To do this, the appeal must be made within sixty (60) days from the date of receipt of the notice of action. DentaQuest will acknowledge the receipt of the appeal within five (5) business days and complete the appeal within thirty (30) calendar days.

What can I do if DentaQuest denies or limits my member's request for a covered service?

You, with the member's consent, can ask for an appeal in writing, or you can call and ask DentaQuest for an appeal. We will send you and the member a one-page appeal form that you, the member, or someone else representing the member can fill out and return to us. Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

How will I find out if services are denied?

We will send you a Provider Determination Letter and the member will receive a Notice of Action Letter.

Timeframes for the Appeal Process/Expedited Appeals

DentaQuest will complete the entire standard appeal process within thirty (30) calendar days after receipt of the initial written or oral request for appeal.

You,(as a member) or DentaQuest can ask for an extension of up to 14 calendar days if there is a need for more information in order to make a decision. DentaQuest will send you (the member) a written notice explaining the reason for the delay.

When does the member have the right to ask for an appeal?

The member has the right to request an appeal if he/she is not satisfied or disagrees with the action. An appeal is the process by which you and/or the member request a review of the action. A Member can request an Appeal for denial of payment for services in whole or in part.

To ensure continuation of currently authorized services, the member must file the appeal sixty (60) calendar days following DentaQuest's mailing of the notice of the action or the intended effective date of the proposed action. The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member. The member also has the option to file for a State Fair Hearing at any time during or after DentaQuest's appeal process.

Can someone from DentaQuest help me file an Appeal?

Yes; please have the Member call our Member Call Center toll-free at 800-436-5286 to request assistance in filing an appeal.

17.02 Expedited Appeals

If the Member or Authorized Representative has requested an emergency appeal, DentaQuest will respond with a resolution within three (3) business days from the date of request for the appeal. Emergency Appeals do not require written and signed documentation from the Member or Authorized Representative. The verbal request is sufficient to process this appeal type.

If the request for an Emergency Appeal is denied by DentaQuest, the appeal request will follow the standard process and timeline requirements. DentaQuest will respond to the Member or Authorized Representative and follow up within one (1) calendar days with written notification of the denied Emergency Appeal request. Non-emergency appeals will be processed within thirty (30) calendar days from the date received.

Who can help me file an Expedited Appeal?

If you need help filing an expedited appeal, call us at 800-436-5286, and a DentaQuest Member Advocate will help you.

18.00 STATE FAIR HEARING INFORMATION

Can a member ask for a State Fair Hearing?

If you, as a member, disagrees with DentaQuest's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want representing you. A provider may be your representative. You or your representative must ask for the fair hearing within one-hundred and twenty (120) days of the date on the plan's letter that tells of the decision you are challenging. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to DentaQuest at:

DentaQuest
Attn: Fair Hearing
Coordinator
P.O. Box 2906
Milwaukee, WI 53201-2906

Or you or your representative should call: 800-436-5286 or fax to: 262-834-2450

If you ask for a fair hearing within ten (10) days from the time you get the decision notice from the dental plan or the effective date of the decision if later, you have the right to keep getting any service the plan denied, at least until the final hearing decision is made. If you do not request a fair hearing within 10 days from the time you get the decision notice or the effective date of the decision if later, the service the dental plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the plan denied.

HHSC will give you a final decision within ninety (90) days from the date you asked for the hearing.

18.01 External Medical Review Information

Can a Member ask for an External Medical Review?
If a Member, as a member of the dental plan, disagrees with the dental plan's decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the dental plan telling the Dental Contractor the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within one-hundred and twenty (120) days of the date the dental plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within one-hundred and twenty (120) days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:
Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Dental Contractor Internal Appeal Decision letter and mail or fax it to DentaQuest by using the address or fax number at the top of the form.

- Call DentaQuest at 1-800-436-5286
- Email CG.Mailbox@greatdentalplans.com

If the Member asks for an External Medical Review within ten (10) days from the time the Member gets the appeal decision from the dental plan, the Member has the right to keep getting any service the dental plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the service the dental plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Dental Contractor at CG.Mailbox@greatdentalplans.com or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling DentaQuest. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the Member must first complete DentaQuest's internal appeals process.

Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Dental Contractor Internal Appeal Decision letter and mail or fax it to DentaQuest by using the address or fax number at the top of the form.

- Call DentaQuest at 1-800-436-5286
- Email CG.Mailbox@greatdentalplans.com

If the Member asks for an External Medical Review within ten (10) days from the time the Member gets the appeal decision from the dental plan, the Member has the right to keep getting any service the dental plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the service the dental plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Dental Contractor at CG.Mailbox@greatdentalplans.com or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling DentaQuest. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the Member must first complete DentaQuest's internal appeals process.

20.00 Program Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate. DentaQuest does not perform Member enrollment functions or determine eligibility of Members. Eligibility for Community First Membership is determined by HHSC or its designee(s).

Providers may contact:
https://www.yourtexasbenefitscard.com/

21.00 Verifying Eligibility

21.01 Member Identification Card

Members will receive a Community First ID card for the program they are eligible for**.** Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if members have other health insurance.

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

Sample of Medicaid STAR+PLUS ID Card:

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

21.02 DentaQuest Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.dentaquest.com. 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. A provider must verify member eligibility and/or authorizations for service.

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 anticipated 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 "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 888-308-9345. Once logged in, select "select patient from the portal menus then choose member eligibility search". 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. **Be sure to verify eligibility on the date of service.** Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department at 888-308-9345 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 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 Member using the Member's identification number . If the system is unable to verify the Member information you entered, you will be Transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service at 888-308-9345.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, enter your NPI (National Provider Identification number).
5. When prompted, enter the last four (4) digits of your Tax ID number.
6. Does the member's ID **only have numbers** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **numbers and letters** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888-308-9345. They will be able to assist you in utilizing either system.

21.03 Disenrollment

When a Member becomes ineligible for Texas Medicaid, the Member is disenrolled from the STAR+PLUS program and from Community First. The Health and Human Services Commission (HHSC) is solely responsible for determining if and when a Member is disenrolled. Under no circumstances can a Provider take retaliatory action against a Member due to disenrollment from either the Provider or a plan.

22.00 MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors,

hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your non-emergency medical needs.
    g. Be sure you have approval from your primary care provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

23.00 Statement of Provider Rights and Responsibilities

Providers shall have the right and responsibility 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 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 DentaQuest.

6. If a recommended course of treatment is not covered, e.g., not approved by DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

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

8. Verify member eligibility, benefits and authorizations required for services to be performed.

24.00 FRAUD REPORTING

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid or CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a Medicaid or CHIP Dental ID.
- Using someone else's Medicaid or CHIP Dental ID.
- **Not telling the truth about the amount of money or resources he or she has to get benefits.**

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184; or
- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form.
- You can report directly to your health plan:

DentaQuest-TX Community First Dental Services
Attention: Utilization Review Department
PO Box 2906
Milwaukee, WI 53201-2906

Providers may also send a fax to: 262-241-7366

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider.
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it.
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation.
  - Dates of events.
  - Summary of what happened.
- When reporting about someone who gets benefits, include:
  - The person's name.
  - The person's date of birth, Social Security number, or case number if you have it.
  - The city where the person lives.
  - Specific details about the waste, abuse, or fraud.

25.00 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 (ADA Claim Form 2012 or newer)

25.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.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. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 888-308-9345. Once logged in, select “Claims/Pre-Authorizations” and then “Dental Claim Entry“. The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

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

25.02 Electronic Authorization Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the “Dentist” section of our website. Submitting Pre-Authorizations 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 pre-authorizations via the website, simply log on to 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. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest’s Customer Service Department at 888-308-9345. Once logged in, select “Claims/Pre-Authorizations” and then “Dental Pre-Auth Entry“.

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

EDIteam@greatdentalplans.com

25.03 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-1293), Tesia 1-800-724-7040, 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.

25.04 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.

25.05 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) dependant 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 and within this manual.

25.06 Paper Claim Submission

- Claims must be submitted on 2012 or later ADA approved claim forms.

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

- The paper claim must contain an acceptable provider signature.

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.

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

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

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

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

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

Claims should be mailed to the following address:

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

For questions, providers may contact DentaQuest Provider Services at 888-308-9345.

25.07 Coordination of Benefits (COB)

Medicaid is the payer of last resort. Providers should ask Members if they have other dental insurance coverage at the time of their appointment. When Medicaid 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 the Medicaid fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

25.08 Member Billing Restrictions

Providers may not bill Members directly for Covered Services. DentaQuest reimburses only those services that are medically necessary and a Covered benefit in the respective program the Member is enrolled in. Medicaid Members do not have co-payments.

Member Acknowledgement Statement

A Provider may bill a Member for a claim denied as not being medically necessary or not a part of a Covered service if both of the following conditions are met:

- A specific service or item is provided at the request of the client
- If the Provider obtains a written waiver from the Member prior to rendering such service. The Member Acknowledgment Statement reads as follows:

"I understand that, in the opinion of (Provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Assistance Program as being reasonable and medically necessary for my care. I understand that DentaQuest through its contract with Community First and HHSC determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

25.09 Private Pay Form (Non-Covered Services Disclosure Form)

There are instances when the dentist may bill the Member. For example, if the Provider accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for payment for all services. In this situation, it is recommended that the Provider use a Private Pay Form. It is suggested that the Provider use the Member Acknowledgement Statement listed above as the Private Pay Form, or use the DentaQuest Non-Covered Services Disclosure Form. Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider could not ask for payment from a Member.

25.10 Filing Limits

DentaQuest must receive your claim requesting payment of services within 95 days from the date of service. Any claim submitted beyond the timely filing limit will be denied for "untimely filing." If a claim is denied for "untimely filing"; the member cannot be billed. If Community First/DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

Clean Claim payment must be made by DentaQuest within 30 days.

25.11 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Customer Contact Center Representative analyzes any claim conditions that would result in non- payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service department at 888-308-9345 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.

25.12 Direct Deposit

As a benefit to participating Providers, DentaQuest offers Electronic Funds Transfer (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 (see Attachment A-9)
- 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
    - Via Mail : DentaQuest TX Community First
PO Box 2906
Milwaukee, WI 53201-2906
ATTN: Provider Enrollment 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. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

26.00 Special Access Requirements

26.01 Interpreter/Translation Services

DentaQuest is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, DentaQuest provides or coordinates the following:

- Our Member Services and Member Advocate department is staffed with Spanish and English bilingual specialists.
- Trained professional language interpreters, including American Sign Language, can be made available face-to-face at your office if necessary, or via telephone, to assist Providers with discussing technical, medical, or treatment information with Members as needed.
- Language Services Associates will be available in 140 languages to assist Providers and Members in communicating with each other when there are no other translators available for the language.
- TYY access for Members who are hearing impaired: 711

26.02 Reading/Grade Level Consideration

An estimated 40–44 million Americans are functionally illiterate and another 50 million are only marginally literate. Nearly half of the functionally illiterate live in poverty and one-fourth report physical, mental or health conditions that prevent them from participating fully in work, school or housework. A study of patients at two public hospitals found that 35 percent of the English-speaking and 62 percent of the Spanish-speaking patients had inadequate or marginal functional health literacy, with more than 81 percent of the elderly groups having limited health literacy. Because of this, DentaQuest understands that many of our members may have limited ability to understand and read instructions. Yet, most people with literacy problems are ashamed and will try to hide them from Providers. Low literacy can mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Member materials should be written at a fourth to sixth grade reading level. The guidelines provided for communication with interpreters are also good guidelines for communicating with members with limited literacy, especially asking the member to repeat your instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines or understanding of treatment. Above all else, be sensitive to the embarrassment the Member may feel about limited literacy. Please contact us for interpretation services should there be a language barrier.

26.03 Cultural Sensitivity

DentaQuest places great emphasis on the wellness of its Members. A large part of quality health care delivery is treating the whole patient and not just the medical

condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Provider's relationship with patients and in the long run the health and wellness of the patients themselves.

Following is a list of principles for health care Providers, to include knowledge, skills and attitudes, related to cultural competency in the delivery of health care services to DentaQuest Members:

Knowledge

- Provider's self understanding of race, ethnicity and influence
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress, socioeconomic status
- Understanding of the cultural differences within minority groups
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network
- Understanding of the differences between "culturally acceptable" behavior of psycho-pathological characteristics of different minority groups
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients
- Understanding of the cultural beliefs of health and help seeking patterns of minority patients
- Understanding of the health service resources for minority patients
- Understanding of the public health policies and its impact on minority patients and communities

Skills

- Ability to interview and assess minority patients based on a psychological/social/ biological/ cultural/ political/ spiritual model
- Ability to communicate effectively with the use of cross cultural interpreters
- Ability to diagnose minority patients with an understanding of cultural differences in pathology
- Ability to avoid under diagnosis or over diagnosis
- Ability to formulate treatment plans that are culturally sensitive to the patient and family's concept of health and illness
- Ability to utilize community resources (church, community-based organizations (CBOs), self-help groups)
- Ability to ask for consultation

Attitudes

- Respect the "survival merits" of immigrants and refugees
- Respect the importance of cultural forces
- Respect the holistic view of health and illness
- Respect the importance of spiritual beliefs
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines
- Be aware of transference and counter transference issues

DentaQuest encourages and advocates for providers to provide culturally competent care for its Members. Providers are also encouraged to participate in training provided by other organizations. You can visit www.hrsa.gov/healthliteracy/training.htm for an online training course developed by the Health Resources and Services Administration (HRSA) and earn CEU and/or CME credits.

26.04 Special Health Care Needs

Members with Special Health Care Needs may have direct access to specialists as appropriate for the Member's condition and identified needs. If you cannot locate a specialist in your area, you may call DentaQuest's Provider Call Center's toll-free telephone number at 888-308-9345 to facilitate a Member referral to a specialist.

27.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations.

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

27.01 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.

27.02 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 and Transitional 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.

28.00 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 Program 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.

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

28.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

- Appropriate radiographs showing clearly 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, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (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 four or more extractions in the same quadrant will be covered subject to consultant review.

28.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs showing clearly 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 showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

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

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

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

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

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

- Request should include a dated post-endodontic radiograph.

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

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

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

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

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

- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

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.

28.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs showing clearly 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 showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

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

Root canal therapy must meet the following criteria:

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

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

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.

28.04 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.

Criteria

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

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

28.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs showing clearly 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 showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

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.
- 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.

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 6 months of denture placement.
- 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.
- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
- Relines will be reimbursed once per denture every 36 months.
- Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for 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.

28.06 Criteria for the Excision of Bone Tissue

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

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

Authorization requirements:

- Appropriate radiographs and/or 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.

28.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

28.08 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 5 years old and younger with extensive procedures to be accomplished.

28.09 Criteria for Periodontal Treatment

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.

Appendix A

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 (the provider) 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.

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	Fee

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

_____
Dentist'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 statements and check either Yes or No:

Question	Yes	No
My dentist has assured me that there are no other covered benefits.		
I am willing to receive services not covered by DentaQuest.		
I am aware that I am financially responsible for paying for these services.		
I am aware that DentaQuest 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 by the dentist.**

_____
Parent or Guardian Signature

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)

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

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 benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

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

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

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 Remaining | 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

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

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

To reorder call 800.947.4746
or go online at adacatalog.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

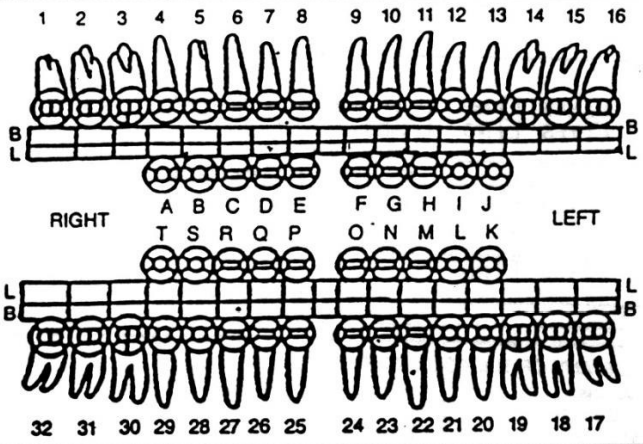
Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following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

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

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last First Middle



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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

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 judgment, 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, and 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.

MEDICAL AND DENTAL HISTORY

Patient Name:_____Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone:_____

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

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

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?
ϒ Yes ϒ NoIf

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? ϒ Yes ϒ No

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

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

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

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

Are you on a special diet? ϒ Yes ϒ No

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

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

For Women Only:

Are you pregnant? ϒ Yes ϒ No

If yes, what month? _____

Are you nursing? ϒ Yes ϒ No

Are you taking birth control pills? ϒ Yes ϒ 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

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS
DISBURSED BY DENTAQUEST USA-TX HHSC Dental Services Program

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 USA Insurance Company, Inc.** 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)

APPENDIX B

Covered Benefits (See Exhibits)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for:

- **STAR+PLUS Waiver - Exhibit C**
- **STAR+PLUS Waiver (Non-Dual) - Exhibit C**
- **STAR+PLUS MMP Waiver - Exhibit C**

Providers with benefit questions should contact DentaQuest's Customer Service department directly at: 888-308-9345, press option 2.

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

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

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

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

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

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

1. the ADA approved service code to submit when billing,
2. brief description of the covered service, 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, and
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). 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

Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health.

However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Eligible STAR+PLUS Medicaid Only Members over the age of 21 years are entitled to the Covered Services as listed, subject to an annual maximum benefit per benefit year of $250.

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

Diagnostic						
Code	Brief Description	Age Limitation	Teeth Covered	Review Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 6 Month(s) Per Provider. One of (D0120, D0140, D0150, D0170) per 1 Day(s) Per patient. Codes D0120 and D0150 must be performed on same date as D0601, D0602, or D0603.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140) per 1 Day(s) Per Provider. Two of (D0140) per 1 Day(s) Per patient. One of (D0120, D0140, D0150, D0170) per 1 Day(s) Per Provider.	

Diagnostic						
Code	Brief Description	Age Limitation	Teeth Covered	Review Required	Benefit Limitations	Documentation Required
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 36 Month(s) Per Provider. One of (D0120, D0140, D0150, D0170) per 6 Month(s) Per Provider OR Location. Codes D0120 and D0150 must be performed on same date as D0601, D0602, or D0603.	
D0170	re-evaluation, limited problem focused	21 and older		No	One of (D0120, D0140, D0150, D0170) per 1 Day(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0274) per 1 Day(s) Per Provider.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Day(s) Per Provider.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 1 Day(s) Per Provider.	
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 36 Month(s) Per Provider OR Location.	
D1110	prophylaxis - adult	21 and older		No	One of (D1110) per 6 Month(s) Per patient.	

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

Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 6 Month(s) Per Provider. One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Day(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Day(s) Per Provider. Two of (D0140) per 1 Day(s) Per patient.	

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 36 Month(s) Per Provider. One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 6 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Day(s) Per Provider.	narrative of medical necessity
D0170	re-evaluation, limited problem focused	21 and older		No	One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Day(s) Per Provider.	
D0171	Re-evaluation post-operative office visit	21 and older		No	One of (D0171) per 6 Month(s) Per patient. Documentation in patient record.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0120, D0140, D0145, D0150, D0160, D0170) per 1 Day(s) Per Provider.	narrative of medical necessity
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No	Two of (D0240) per 1 Day(s) Per Provider.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No	One of (D0250) per 1 Day(s) Per Provider.	
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per Provider.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per Provider.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per Provider.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per Provider.	

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0277) per 1 Day(s) Per Provider. One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0310	sialography	21 and older		No		
D0320	temporomandibular joint arthogram, including injection	21 and older		No		
D0321	other temporomandibular joint films, by report	21 and older		No		
D0322	tomographic survey	21 and older		No		
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	
D0340	cephalometric radiographic image	21 and older		No	One of (D0340) per 1 Day(s) Per Provider.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	21 and older		No	One of (D0350) per 1 Day(s) Per Provider.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	21 and older		Yes	Three of (D0367) per 12 Month(s) Per patient.	narrative of medical necessity
D0415	bacteriologic studies	21 and older		No		
D0460	pulp vitality tests	21 and older		No	One of (D0460) per 1 Day(s) Per Provider.	
D0470	diagnostic casts	21 and older		No	Not billable with crowns, prosthodontics (fixed orremovable) orthodontics,or diagnostic work up.	
D0502	other oral pathology procedures, by report	21 and older		No		
D0601	Caries risk assessment and documentation, with a finding of low risk	21 and older		No	Codes D0120, D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	21 and older		No	Codes D0120, D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0603	Caries risk assessment and documentation, with a finding of high risk	21 and older		No	Codes D0120, D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0999	unspecified diagnostic procedure, by report	21 and older		Yes		narrative of medical necessity

Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1330	oral hygiene instructions	21 and older		No	One of (D1110, D1120, D1206, D1208, D1330) per 1 Day(s) Per patient. One of (D1330) per 12 Month(s) Per patient.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1352) per 36 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1516	space maintainer --fixed--bilateral, maxillary	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D1516, D1526) per 24 Month(s) Per patient per arch.	
D1517	space maintainer --fixed--bilateral, mandibular	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D1517, D1527) per 24 Month(s) Per patient per arch.	
D1520	space maintainer-removable-unilateral	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	
D1526	space maintainer --removable--bilateral, maxillary	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D1516, D1526) per 24 Month(s) Per patient per arch.	
D1527	space maintainer --removable--bilateral, mandibular	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D1517, D1527) per 24 Month(s) Per patient per arch.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	21 and older		No	Not allowed within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	21 and older		No	Not allowed within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed within 6 months of initial placement.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed by same provider OR location that placed appliance.	
D1557	Removal of fixed bilateral space maintainer- Maxillary	21 and older		No	Not allowed by same provider OR location that placed appliance.	
D1558	Removal of fixed bilateral space maintainer- Mandibular	21 and older		No	Not allowed by same provider OR location that placed appliance.	

Reimbursement includes local anesthesia.
Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months.
Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.
Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services. BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 1 Year(s) Per patient per tooth, per surface.	
D2510	inlay - metallic -1 surface	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2520	inlay-metallic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2530	inlay-metallic-3+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 120 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2650	inlay-composite/resin 1surface	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2651	inlay-composite/resin-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2652	inlay-composite/resin-3+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2662	onlay-composite/resin-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2663	onlay-composite/resin-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2664	onlay-composite/resin-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2710	crown - resin-based composite (indirect)	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2720	crown-resin with high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2721	crown - resin with predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2722	crown - resin with noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 4 - 13, 20 - 29	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 4 - 13, 20 - 29	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 4 - 13, 20 - 29	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 4 - 13, 20 - 29	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2780	crown - ¾ cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2781	crown - ¾ cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2782	crown - ¾ cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2783	crown - ¾ porcelain/ceramic	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2794	Crown- Titanium and Titanium Alloys	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No	One of (D2910) per 6 Month(s) Per patient per tooth.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	One of (D2915) per 6 Month(s) Per patient per tooth.	

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	One of (D2920) per 6 Month(s) Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932) per 12 Month(s) Per Provider per tooth.	
D2932	prefabricated resin crown	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2932) per 12 Month(s) Per Provider per tooth.	
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed with any other D2000, D3000, or D6000 series code, but is allowed with D3110 and D3120.	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950) per 12 Month(s) Per patient per tooth. One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	One of (D2951) per 60 Month(s) Per patient per tooth.	
D2952	cast post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2952) per 60 Month(s) Per patient per tooth.	
D2953	each additional cast post - same tooth	21 and older	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2952.	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2952, D3950) per 1 Day(s) Per patient per tooth.	
D2955	post removal (not in conjunction with endodontic therapy)	21 and older	Teeth 1 - 32	No	One of (D3346, D3347, D3348) per 1 Day(s) Per patient per tooth.	
D2957	each additional prefabricated post - same tooth	21 and older	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2954.	
D2960	labial veneer (laminate)-chair	21 and older	Teeth 1 - 32	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D2961	labial veneer (resin laminate) - laboratory	21 and older	Teeth 1 - 32	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D2962	labial veneer (porc laminate) - laboratory	21 and older	Teeth 1 - 32	Yes		Narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2971	additional procedures to construct new crown under partial denture framework	21 and older	Teeth 1 - 32	Yes	Four of (D2971) per 1 Lifetime Per patient per tooth.	
D2980	crown repair, by report	21 and older	Teeth 1 - 32	No		
D2999	unspecified restorative procedure, by report	21 and older	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, pre-op x-ray(s)

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. 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 any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.
Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.
Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.
The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.
BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3110	pulp cap - direct (exluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	(D3110) and (D3120) will not be reimbursed when submitted with the following procedure codes for the same Tooth, same Date of Service: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.	

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	(D3120) will not be reimbursed when submitted with the following procedure codes for the same Tooth, same Date of Service: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2510, D2520, D2530, D2542, D2343, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2910, D2915, D2920, D2930, D2931, D2932, D2933, D2934, D2950, D2951, D2952, D2953, D2954, D2955, D2957, D2960, D2961, D2962, D2971, D2980, D2999, D3220, D3310, D3320, or D3330	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	21 and older	Teeth 2 - 15, 18 - 31, A - T	No	One of (D3220, D3230, D3240, D3310, D3320, D3330) per 6 Month(s) Per patient per tooth.	
D3221	pulpal debridement, primary and permanent teeth	21 and older	Teeth 1 - 32, A - T	No	One of (D3220, D3221) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Not allowed by same provider or dental office that performed original root canal therapy.	Narr. of med. necessity, pre and post-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	No		

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 1 - 32	No		
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D3430	retrograde filling - per root	21 and older	Teeth 1 - 32	No		
D3450	root amputation - per root	21 and older	Teeth 1 - 32	No		
D3460	endodontic endosseous implant	21 and older	Teeth 1 - 32	Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D3470	intentional reimplantation	21 and older	Teeth 1 - 32	No		
D3910	surgical procedure for isolation of tooth with rubber dam	21 and older	Teeth 1 - 32	No		
D3920	hemisection (including any root removal), not incl root canal therapy	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No		
D3950	canal preparation and fitting of preformed dowel or post	21 and older	Teeth 1 - 32	No		narr. of med. necessity, pre-op x-ray(s)
D3999	unspecified endodontic procedure, by report	21 and older	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, pre-op x-ray(s)

Claims for preventive dental procedure codes D1110, D1206, and D1208 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant.	Narr. of med. necessity, pre and post-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4212) per 1 Lifetime Per patient per tooth.	
D4230	anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older		Yes	One of (D4230, D4231) per 24 Month(s) Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4231	anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	21 and older		Yes	One of (D4230, D4231) per 24 Month(s) Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant.	Narr of med necessity & full mouth xrays

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant.	Narr of med necessity & full mouth xrays
D4245	apically positioned flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4245) per 24 Month(s) Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per quadrant.	Narr. of med. necessity, pre and post-op x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 12 Month(s) Per patient per quadrant.	Full mouth xrays, perio charting & narrative
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 12 Month(s) Per patient per quadrant.	Full mouth xrays, perio charting & narrative
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	21 and older	Teeth 1 - 32	Yes	One of (D4266) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	21 and older	Teeth 1 - 32	Yes	One of (D4267) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	Yes	One of (D4270) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	Yes	One of (D4273) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	Yes	One of (D4274) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4275	soft tissue allograft	21 and older	Teeth 1 - 32	Yes	One of (D4275) per 1 Day(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4276	combined connective tissue and double pedicle graft	21 and older	Teeth 1 - 32	Yes	One of (D4276) per 24 Month(s) Per patient per tooth. Not payable in addition to D4273 and D4276 for the same date of service.	narr. of med. necessity, pre-op x-ray(s)
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32	Yes	One of (D4277) per 24 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32	Yes	Must be billed on the same date of service as D4277.	narr. of med. necessity, pre-op x-ray(s)
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32	Yes	One of (D4283) per 1 Lifetime Per patient per tooth. D4283, D4285 limited to three teeth per site same day same provider. D4283 is an add-on code and must be billed along with procedure code D4273.	narr. of med. necessity, pre-op x-ray(s)
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32	Yes	One of (D4285) per 1 Lifetime Per patient per tooth. D4283, D4285 limited to three teeth per site same day same provider. D4285 is an add-on code and must be billed along with procedure code D4275.	narr. of med. necessity, pre-op x-ray(s)
D4320	provision splinting - intracoronal	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D4320, D4321) per 1 Lifetime Per patient per arch.	narr. of med. necessity, pre-op x-ray(s)
D4321	provision splinting - extracoronal	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D4320, D4321) per 1 Lifetime Per patient per arch.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	D4341 is denied if provided within 21 days of D4355. D4341 and D4342 are denied when submitted for the same DOS as other D4000 series codes, except D4341 and D4342, or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525, Any Provider.	Full mouth xrays & perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	D4342 and D4341 are denied when submitted for the same DOS as other D4000 series codes, except D4341 and D4342, or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525, Any Provider.	
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	21 and older		No		

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		Yes	One of (D4355) per 36 Month(s) Per patient. One of (D4210, D4211, D4230, D4231, D4240, D4241, D4245, D4249, D4260, D4263, D4264, D4265, D4266, D4267, D4268, D4270, D4271, D4273, D4274, D4275, D4276, D4320, D4321, D4341, D4342, D4355, D4381, D4910, D4920, D4999) per 1 Day(s) Per patient. Not allowed within 21 days of D4341 or D4342.	narr. of med. necessity, pre-op x-ray(s)
D4381	localized delivery of antimicrobial agents	21 and older	Teeth 1 - 32	Yes	One of (D4381) per 24 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient. One of (D4355) per 1 Day(s) Per patient. Once a D4910 is used, then only a D4910 can be used. Cannot be used in conjunction with D4341 on the same date of service. Only allowed in conjunction with a history of periodontal pre-surgical or surgical treatment, excluding D4355. Limit is 2 times per year either code D1110 or D4910 but not both.	narr. of med. necessity, pre-op x-ray(s)
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	21 and older		No		
D4999	unspecified periodontal procedure, by report	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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

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

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

Dentures will not be preauthorized when:
Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

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.

Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	No	One of (D5110, D5130) per 60 Month(s) Per patient.	
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	No	One of (D5120, D5140) per 60 Month(s) Per patient.	
D5130	immediate denture - maxillary	21 and older	Per Arch (01, UA)	No	One of (D5110, D5130) per 60 Month(s) Per patient. One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	21 and older	Per Arch (02, LA)	No	One of (D5120, D5140) per 60 Month(s) Per patient. One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5211, D5213) per 60 Month(s) Per patient.	
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5212, D5214) per 60 Month(s) Per patient.	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		No	One of (D5211, D5213) per 60 Month(s) Per patient.	
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		No	One of (D5212, D5214) per 60 Month(s) Per patient.	
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5221) per 1 Lifetime Per patient.	
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5222) per 1 Lifetime Per patient.	
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5223) per 1 Lifetime Per patient.	
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5224) per 1 Lifetime Per patient.	

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5281	removable unilateral partial denture - one piece cast metal	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D5281) per 60 Month(s) Per patient per quadrant.	
D5410	adjust complete denture - maxillary	21 and older		No	One of (D5410) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	21 and older		No	One of (D5411) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture-maxillary	21 and older		No	One of (D5421) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	21 and older		No	One of (D5422) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No	One of (D5621) per 12 Month(s) Per patient.	
D5622	repair cast partial framework, maxillary	21 and older		No	One of (D5622) per 12 Month(s) Per patient.	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No		

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	21 and older		No	One of (D5670) per 36 Month(s) Per patient. Not covered within 6 months of placement. Denied with D5211, D5213, D5281, D5640.	
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	21 and older		No	One of (D5671) per 36 Day(s) Per patient. Not covered within 6 months of placement. Denied with D5211, D5213, D5281, D5640.	
D5710	rebase complete maxillary denture	21 and older		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5711	rebase complete mandibular denture	21 and older		No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5720	rebase maxillary partial denture	21 and older		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5721	rebase mandibular partial denture	21 and older		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731) per 36 Month(s) Per patient per tooth. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	21 and older		No	One of (D5740) per 36 Month(s) Per patient per tooth. Not covered within 6 months of placement.	
D5741	reline mandibular partial denture (chairside)	21 and older		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of placement.	

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	21 and older		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of placement.	
D5810	interim complete denture-maxillary	21 and older		Yes	One of (D5810) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5811	interim complete denture-mandibular	21 and older		Yes	One of (D5811) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (maxillary)	21 and older		Yes	One of (D5820) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5821	interim partial denture-mandibular	21 and older		Yes	One of (D5821) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5850	tissue conditioning, maxillary	21 and older		No		
D5851	tissue conditioning,mandibular	21 and older		No		
D5862	precision attachment, by report	21 and older	Teeth 1 - 32	No		
D5863	Overdenture - complete maxillary	21 and older		Yes	One of (D5110, D5130, D5863) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5864	Overdenture - partial maxillary	21 and older		Yes	One of (D5211, D5213, D5864) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5865	Overdenture - complete mandibular	21 and older		Yes	One of (D5120, D5140, D5865) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5866	Overdenture - partial mandibular	21 and older		Yes	One of (D5212, D5214, D5866) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5899	unspecified removable prosthodontic procedure, by report	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5912	facial moulage (complete)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5913	nasal prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5914	auricular prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5915	orbital prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5916	ocular prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5919	facial prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5922	nasal septal prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5923	ocular prosthesis, interim	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5924	cranial prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5925	facial augment implant prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5926	nasal prosthesis, replacement	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5927	auricular prosthesis, replace	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5928	orbital prosthesis, replace	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5929	facial prosthesis, replacement	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5933	obturator prosthesis, modification	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5936	obturator prosthesis, interim	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5951	feeding aid	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5952	speech aid prosthesis, pediatric	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5953	speech aid prosthesis, adult	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5954	palatal augment prosthesis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5958	palatal lift prosthesis, interim	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5983	radiation carrier	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5984	radiation shield	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5985	radiation cone locator	21 and older		Yes		Narr. of med. necessity, pre and post-op x-ray(s)
D5986	fluoride gel carrier	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5987	commissure splint	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5988	surgical splint	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

BILLING AND REIMBURSEMENT FOR CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETIC SHALL BE BASED UPON THE CEMENTATION DATE.
Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by DentaQuest is noted below:
· At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).
· The space cannot be filled with a removable partial denture.
· The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).
· Each abutment or each pontic constitutes a unit in a bridge.
· Porcelain is allowed on all teeth.
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.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6211	pontic-cast base metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6212	pontic - cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6240	pontic-porcelain fused-high noble	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6241	pontic-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6242	pontic-porcelain fused-noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6250	pontic-resin with high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6251	pontic-resin with base metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6252	pontic-resin with noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6545	retainer - cast metal fixed	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6549	Resin retainer-For resin bonded fixed prosthesis	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient.	Narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6710	crown - indirect resin based composite	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient.	Narr. of med. necessity, pre and post-op x-ray(s)
D6720	crown-resin with high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6721	crown-resin with base metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6722	crown-resin with noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6740	retainer crown, porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6750	crown-porcelain fused high noble	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6751	crown-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6752	crown-porcelain fused noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6780	crown-3/4 cst high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6790	crown-full cast high noble	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6791	crown - full cast base metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6792	crown - full cast noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	Narr. of med. necessity, pre and post-op x-ray(s)
D6920	connector bar	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D6920) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	21 and older		No	Not allowed within 6 months of initial placement.	
D6940	stress breaker	21 and older	Teeth 1 - 32	No	One of (D6940) per 60 Month(s) Per patient per tooth.	
D6950	precision attachment	21 and older	Teeth 1 - 32	No	One of (D6950) per 60 Month(s) Per patient per tooth.	
D6975	coping - metal	21 and older	Teeth 1 - 32	No	One of (D6975) per 60 Month(s) Per patient per tooth.	
D6980	fixed partial denture repair	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)

Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection.
The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to clinical review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. Providers should always check the member's eligibility prior to rendering services.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 5, 12, 14 - 19, 30 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4, 6 - 11, 13, 20 - 29	Yes		narr. of med. necessity, pre-op x-ray(s)

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	21 and older	Teeth 1 - 16	Yes		narr. of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	21 and older	Teeth 1 - 16	Yes	May not be paid for the same date of service as D7260.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No		
D7272	tooth transplantation (inlcudes reimplantation from one site to another)	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	21 and older	Teeth 1 - 32	No	May not be paid for the same date of service as D7280.	

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7286	incisional biopsy of oral tissue-soft	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7290	surgical repositioning of teeth	21 and older	Teeth 1 - 32	No		
D7291	transseptal fiberotomy, by report	21 and older	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D7340) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7350	vestibuloplasty - ridge extension	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D7350) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No		
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No		
D7413	excision of malignant lesion up to 1.25 cm	21 and older		No		
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		No		
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	21 and older		No		
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	21 and older		No		

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		
D7465	destruction of lesion(s) by physical or chemical method, by report	21 and older		No		
D7472	removal of torus palatinus	21 and older		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Not allowed on same day as extraction.	
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	21 and older		No		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		No		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	21 and older		No		
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		No		
D7820	closed reduction dislocation	21 and older		No		
D7880	occlusal orthotic device, by report	21 and older		Yes	One of (D7880) per 60 Month(s) Per patient.	narrative of medical necessity

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7899	unspecified TMD therapy, by report	21 and older		Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	21 and older		No		
D7911	complicated suture-up to 5 cm	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7912	complex suture - greater than 5cm	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	21 and older		Yes		narrative of medical necessity
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7962	lingual frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D7970) per 1 Lifetime Per patient per arch.	narr. of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	21 and older	Teeth 1 - 32	No	One of (D7971) per 1 Lifetime Per patient per tooth.	
D7972	surgical reduction of fibrous tuberosity	21 and older	Teeth 1, 16, 17, 32	No	Two of (D7972) per 1 Lifetime Per patient.	narrative of medical necessity
D7980	surgical sialolithotomy	21 and older		No		
D7983	closure of salivary fistula	21 and older		No		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	21 and older		Yes	One of (D7997) per 1 Lifetime Per patient. Not allowed by provider or office that placed the appliance.	narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Waiver Benefit: Dental services are those services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include:
• Emergency dental treatment procedures that are necessary to control bleeding, relieve pain, and eliminate acute infection;
• Operative Preventive procedures that are required to prevent the imminent loss of teeth;
• Routine and preventive dental treatment procedures necessary to maintain good oral health;
• Treatment of injuries to the teeth or supporting structures; and
• Dentures and cost of fitting and preparation for dentures, including extractions, molds,etc.

The annual cost limit cap of this service is $5,000 per individual service plan (ISP)waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	Not allowed for prescriptions or medication.	
D9120	fixed partial denture sectioning	21 and older	Teeth 1 - 32	No		
D9210	local anesthesia not in conjuction with operative or surgical procedures	21 and older		No	Not allowed with D9248.	
D9211	regional block anesthesia	21 and older		No	Not allowed with D9248.	
D9212	trigeminal division block anesthesia	21 and older		No	Not allowed with D9248.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per patient. (D9222) to be billed for one 15 minute increment. Not allowed on same day as D9248. One of (D9230) per date of service. Not allowed with D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9223) per 12 Month(s) Per patient. Not allowed with D9248.Add-on procedure code D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222.	narrative of medical necessity

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed with D9248. May not be submitted more than one per client per day.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per patient. (D9239) to be billed for one 15 minute increment. Not allowed on same day as D9248. One of (D9230) per date of service. Not allowed with D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Eight of (D9243) per 12 Month(s) Per patient. Not allowed with D9248. “Add-on procedure code D9243 must be billed by the same provider, same claim in conjunction with primary procedure code D9239.”	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		No	Two of (D9248) per 12 Month(s) Per patient. D9248 will be denied when submitted for the same date of service as procedure code D9420, any provider.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	Should be billed as D0160 for specialist who is providing treatment.	
D9410	house/extended care facility call	21 and older		No		
D9420	hospital or ambulatory surgical center call	21 and older		No	One of (D9420) per 12 Month(s) Per patient. One per hospital or ASC case.	
D9430	office visit for observation - no other services performed	21 and older		No	No other services allowed. Not to be used for post-operative care.	
D9440	office visit - after regularly scheduled hours	21 and older		No	Not to be used for post-operative care.	narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	One of (D9610, D9612) per 1 Day(s) Per patient. Not allowed with D9223.	Description of drugs with claim
D9612	therapeutic drug injection - 2 or more medications by report	21 and older		Yes	One of (D9610, D9612) per 1 Day(s) Per patient. Not allowed with D9223.	Description of drugs with claim
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Not allowed with D9223, D9230, D9243, D9248, D9610 or D9920.	narrative of medical necessity
D9910	application of desensitizing medicament	21 and older		No	Not to be used as a base or a liner.	

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9920	behavior management, by report	21 and older		Yes	One of (D9920) per 1 Day(s) Per patient. Denied if billed with D9248, D0120-D0180, D1110, D1120 or D0210-D0363. Diagnosis and level of mental retardation must be included in narrative.	narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient.	narrative of medical necessity
D9950	occlusion analysis-mounted case	21 and older		Yes		narrative of medical necessity
D9951	occlusal adjustment - limited	21 and older		No	One of (D9951) per 1 Year(s) Per Provider.	
D9952	occlusal adjustment - complete	21 and older		No	One of (D9952) per 1 Lifetime Per Provider.	
D9970	enamel microabrasion	21 and older	Teeth 1 - 32	No	One of (D9970) per 1 Day(s) Per patient. One service per day, per provider.	
D9974	internal bleaching - per tooth	21 and older	Teeth 1 - 32	No		
D9999	unspecified adjunctive procedure, by report	21 and older		No		narrative of medical necessity