DentaQuest USA Insurance Company, Inc.

DentaQuest Provider Office Reference Manual

TX HHSC Dental Services- Medicaid and CHIP

Provider Manual

DentaQuest TX
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

1-800-896-2374
www.dentaquest.com

This document contains proprietary and confidential information and
may not be disclosed to others without written permission
©Copyright 2020. All rights reserved.

Version 7.1

Current Dental Terminology © American Dental Association. All Rights Reserved.

TABLE OF CONTENTS

TX HHSC Dental Services- Medicaid and CHIP 1
Provider Manual 1
TABLE OF CONTENTS 2
Introduction to DentaQuest 7
Quick Reference Phone List 7
Program Objectives 8
Role of Main Dental Home 8
Are you building a "Dental Home" for your Members? 8
Role of First Dental Home Initiative for Medicaid Members 8
Covered Services 9
Texas Health Steps Dental Services (Medicaid Only) 9
Texas Health Steps Medical Checkup Periodicity Schedule for Infant, Children, and Adolescents 9
Exception to Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services For Texas Health Steps Dental Procedures 11
Exception-to-Periodicity Oral Evaluation 11
Exception-to-Periodicity Dental Checkup 12
Exception-to-Periodicity Emergency or Trauma Related Oral Evaluation 12
Adjunctive General Services 12
Children of Migrant Farmworkers 12
Children's Medicaid Dental Covered Services 13
Texas Medicaid Dental Program Covered Services include the following Medically Necessary services. 13
CHIP Dental Covered Services 13
Texas CHIP Dental Program Covered Services include the following Medically Necessary services. 14
C. Quality Management 14
Quality Improvement Program (Policies 200 Series) 14
Utilization Management Program (Policies 500 Series) 15
Introduction: 15
Community Practice Patterns: 15
Evaluation: 16
Results: 16
D. Provider Responsibilities 16
General Responsibilities 16
Availability and Accessibility 16
Main Dental Home Responsibilities 17
First Dental Home Initiative Responsibilities 17
Updates to Contact Information 18
Plan Termination 18
Referral to Specialists Process 19
Referrals to Specialists 19
Verify Member Eligibility and/or Authorizations for Service 20
Member Eligibility 20
Access to eligibility information via the Provider Web Portal 20
Access to eligibility information via the IVR line 21
Authorizations of Service 22
Submitting Authorization or Claims with X-Rays 23
Electronic Attachments 24
Continuity of Care 24
Dental Records 25
Organization 25

Current Dental Terminology © American Dental Association. All Rights Reserved.

Compliance 29
Health Insurance Portability and Accountability Act (HIPAA) 29
Access to Second Opinion 30
Justification Regarding Out-of-Network Referrals 30
Informed Consent for Utilization of Papoose Boards 31
Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services 32
Definitions 32
EMERGENCY Treatments and Authorizations 32
Requirements for Scheduling of Appointments 33
Coordination of Non-Capitated Services 33
Medicaid Services Not Covered by DentaQuest 33
MEDICAL TRANSPORTATION PROGRAM (MTP) 33
CHIP Services Not Covered by DentaQuest 34
Effective January 1, 2019 - Retro eligibility Recoupment Process 34
Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment) 35
E. Medicaid Dental Services Provider Complaint and Appeal Process 35
Medicaid Provider Complaints 35
Medicaid Provider Appeals 36
Peer to Peer Reviews 36
F. Medicaid Dental Services Member Complaint and Appeal Process 36
Medicaid Member Complaint 37
What should I do if I have a complaint? 37
If the Member is not satisfied with the outcome, who else can they call? 37
Medicaid Member Appeals 38
What can I do if DentaQuest denies or limits my Member's request for a covered service? 38
How will I find out if services are denied? 38
Timeframes for the Appeal Process 38
When does the Member have the right to ask for an appeal? 39
Can someone from DentaQuest help a Member file an appeal? 39
Medicaid Member Expedited Appeals 39
How to Request an Expedited Appeal 39
Timeframes for Expedited Appeals 39
What happens if DentaQuest denies the request for an Expedited Appeal? 39
Who can help me file an Expedited Appeal? 39
State Fair Hearing Information 40
Can a Member ask for a State Fair Hearing? 40
G. CHIP Provider Complaints and Appeals 40
CHIP Provider Complaints 40
CHIP Provider Appeals 41
Peer to Peer Reviews 42
"Like Specialty" Peer to Peer Reviews 42
Procedure 42
CHIP Member Complaints and Appeals 43
CHIP Member Complaint 43
What should I do if I have a complaint? 44
Who do I call? 44
Can someone from DentaQuest help a Member file a complaint? 44
How long will it take to investigate and resolve my complaint? 44
If I am not satisfied with the outcome, who else can I call? 44
CHIP Member Appeal 45
What can I do if DentaQuest denies or limits my patient's request for a covered service? 45
How will I find out if the appeal is denied? 45

Current Dental Terminology © American Dental Association. All Rights Reserved.

Timeframes for the Appeal Process ... 46
When does a Member have the right to request an appeal? ... 46
Can someone from DentaQuest help the Member file an appeal? ... 47
CHIP Member Expedited Appeals ... 47
How to Request an Expedited Appeal ... 47
Timeframes for Expedited Appeals ... 47
What happens if DentaQuest denies the request for an Expedited Appeal? ... 47
Who can help me file an Expedited Appeal? ... 47
Independent Review Organization (IRO) for External CHIP Appeal Reviews ... 48
What is an Independent Review Organization? ... 48
How do I request a review by an Independent Review Organization? ... 48
HHS-Administered Federal External Review Request Form ... 48
HHS Federal External Review Process Appointment of Representative Form ... 48
How long will it take to investigate and resolve my external appeal? ... 49
Standard External Review requests: ... 49
Expedited Independent Review Organization request ... 49
How long will it take to investigate and resolve my expedited external appeal? ... 50
For an expedited External Review request: ... 50
HHSC Oversight ... 50
H. Medicaid Member Eligibility and Added Benefits ... 50
Eligibility ... 50
Verifying Eligibility ... 50
Main Dental Home Verification ... 50
DentaQuest Member Identification Card ... 51
Call DentaQuest ... 51
Automated Inquiry System line/TXMedConnect ... 51
Automatic Re-enrollment ... 52
Disenrollment ... 52
Can DentaQuest ask that my child get dropped from their dental plan? ... 52
Medicaid Plan Changes ... 52
Medicaid Added Benefits ... 53
Medicaid Member Value Added Services ... 53
Additional value-added services: ... 53
I. CHIP Member Eligibility and Added Benefits ... 53
Eligibility ... 53
Verifying Eligibility ... 54
DentaQuest CHIP Identification Card ... 54
Re-enrollment ... 55
Disenrollment ... 55
Can DentaQuest ask that my child get dropped from their dental plan? ... 55
CHIP Plan Changes ... 55
CHIP Added Benefits ... 56
CHIP Member Value Added Services ... 56
Member Rights and Responsibilities ... 56
MEMBER RIGHTS ... 57
Medicaid Member Responsibilities ... 59
CHIP DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITIES ... 60
CHIP Member Rights ... 60
CHIP Member Responsibilities ... 61
Fraud and Abuse Reporting ... 61
Do you want to report Waste, Abuse, or Fraud? ... 61
To report waste, abuse, or fraud, choose one of the following: ... 62

Current Dental Terminology © American Dental Association. All Rights Reserved.

To report waste, abuse or fraud, gather as much information as possible. 62
J. Medicaid and CHIP Encounter Data, Billing, and Claims Administration 62
Where to Send Claims/Encounter Data 62
Electronic Claim Submission Utilizing DentaQuest's Internet Website 63
Electronic Authorization Submission Utilizing DentaQuest's Internet Website 63
Electronic Claim Submission via Clearinghouse 64
HIPAA Compliant 837D File 64
NPI Requirements for Submission of Electronic Claims 64
Paper Claim Submission 64
Coordination of Benefits (COB) 65
Receipt and Audit of Claims 66
Second Opinion Reviews and Regional Screening 66
Form to Use 66
CHIP Cost Sharing Schedule 66
No Co-Payments for Medicaid Members 68
Billing Members 68
Member Acknowledgement Statement 68
Private Pay Form Agreement 68
Time Limit for Submission of Claims/Claims Appeals 68
Claims Payment 69
K. Medicaid and CHIP Special Access Requirements 69
Interpreter/Translation Services 69
Dental Contractor/Provider Coordination 70
Reading/Grade Level Consideration 70
Cultural Sensitivity 70
Knowledge 71
Skills 71
Attitudes 71
Specialty Health Care Needs 72
L. DentaQuest Information 72
Standard of Care 72
Identical Restoration: (same tooth, exact same service), same provider or location (Prior Authorization or Pre-Payment Review) 72
Similar Restoration: (same tooth, at least one surface repeated), same provider or location (Prior Authorization or Pre-Payment Review) 73
Professional Conduct 74
Credentialing (Policies 300 Series) 74
Broken Appointments – Best Practices 75
Logging Broken Appointments in the Provider Web Portal 76
Direct Deposit 76
Advance Directives 77
Clinical Criteria 78
Criteria for Dental Extractions 79
Documentation needed for authorization procedure: 79
Criteria 79
Criteria for Cast Crowns 80
Documentation needed for authorization of procedure: 80
Criteria 80
Criteria for Endodontics 81
Documentation needed for authorization of procedure: 81
Criteria 81
Criteria for Stainless Steel Crowns 82
Documentation needed for authorization of procedure: 82

Current Dental Terminology © American Dental Association. All Rights Reserved.

Criteria ... 82
Criteria for Authorization of Operating Room (OR) Cases Documentation needed for authorization of procedure: ... 83
Criteria ... 84
Criteria for Removable Prosthodontics (Full and Partial Dentures) ... 84
Documentation needed for authorization of procedure: ... 84
Criteria ... 84
Criteria ... 86
Criteria for the Excision of Bone Tissue ... 86
Criteria for the Determination of a Non-Restorable Tooth ... 87
Criteria for General Anesthesia and Intravenous (IV) Sedation Documentation needed for authorization of procedure: ... 87
Criteria ... 87
For Members Ages Six and Under ... 88
Dental Anesthesiologist ... 89
Treating Dentist ... 90
Medical Anesthesiologist ... 90
Treating Dentist ... 91
Medical Anesthesiologist and / or Facility ... 91
Treating Dentist ... 91
Criteria for Periodontal Treatment ... 92
Criteria ... 92
Appendix A Definitions ... 93
Appendix B Forms to Use ... 95
Non-Covered Service Disclosure Form ... 98
OrthoCAD Submission Form ... 99
Continuation of Care Submission Form ... 100
Children's Medicaid Dental Services Managed Care Orthodontia Review Policy and Procedure- Texas ... 101
Purpose ... 101
Definitions ... 101
Policy ... 101
RECALL EXAMINATION ... 113
Authorization for Dental Treatment ... 114
MEDICAL AND DENTAL HISTORY ... 115
AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST USA-TX HHSC Dental Services Program ... 117
INSTRUCTIONS ... 117
MAINTENANCE TYPE: ... 117
ACCOUNT HOLDER INFORMATION: ... 117
APPENDIX C ... 119
Covered Benefits (See Exhibits) ... 119
800.896.2374, press option 2 ... 119
DentaQuest Authorization Process ... 121
IMPORTANT ... 121
Exhibit A Benefits Covered for TX Medicaid Child (Under 21) ... 123
Exhibit B Benefits Covered for TX CHIP Child (Under 19) ... 180

Current Dental Terminology © American Dental Association. All Rights Reserved.

Introduction to DentaQuest

Quick Reference Phone List

Provider Services-Medicaid and CHIP
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

1-800-896-2374
Monday – Friday; 8 a.m. – 6 p.m.

Fax numbers:
Claims/payment issues: 262-241-7379
Claims to be processed: 262-834-3589
All other: 262-834-3450

Claims Questions:
txclaims@dentaquest.com

Medicaid Member Services
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

1-800-516-0165
Monday – Friday; 8 a.m. – 6 p.m.

CHIP Member Services
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

1-800-508-6775
Monday – Friday; 8 a.m. – 6 p.m.

TMHP Contact Center/Automated Inquiry System (AIS)
1-800-925-9126 or 512-335-5986
www.tmhp.com

*For interpretation/translation services, please contact the Provider Services Department at:
1-800-896-2374

Authorizations should be sent to:
TX HHSC Dental Program- Authorization
P.O. Box 2906 Milwaukee,
WI 53201-2906
Fax: 262-241-7150 or 888-313-2883

Credentialing applications should be sent to:
TX HHSC Dental Program- Credentialing
P.O. Box 2906 Milwaukee,
WI 53201-2906
Credentialing Hotline: 800.233.1468
Fax: 262-241-4077

Claims should be sent to:
TX HHSC Dental Program –Claims
Box 2906 Milwaukee, WI 53201-2906

TTY Service
Federal Relay Service 7-1-1

Current Dental Terminology © American Dental Association. All Rights Reserved.

Program Objectives

The primary objective of Texas Medicaid and CHIP Dental Services programs are to create a comprehensive dental care system 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.

Role of Main Dental Home

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

Effective March 1, 2012, DentaQuest USA Insurance Company, Inc. (DentaQuest) implemented the Dental Home program in Texas for Medicaid and CHIP Members.

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

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

Main Dental Home assignment must be verified on the DentaQuest Provider Web Portal (located in the "Providers Only" section of DentaQuest's website at www.dentaquest.com). You may also contact DentaQuest's Customer Service Department at 1-800-896-2374 to verify Main Dental Home assignment.

Role of First Dental Home Initiative for Medicaid Members

Medicaid Members from six (6) through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every sixty (60) days if medically necessary.

Providers must be certified to be a Texas Health Steps Dentist. To become a First Dental Home Initiative Provider (Texas Health Steps), the dentist must complete either the online module or in-person training and submit registration information.

Current Dental Terminology © American Dental Association. All Rights Reserved.

The Texas Health Steps online First Dental Home Module is available at www.txhealthsteps.com. Go to "Start a free course now" and choose "First Dental Home" from the drop down menu.

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

Only certified, participating First Dental Home Providers may bill a D0145 for a first dental home oral evaluation. The member is only allowed one of D0120 or D0150 in a six month period. D1330, D1206, and D1208 will be denied when billed on the same date of service as D0145.

Covered Services

Texas Health Steps Dental Services (Medicaid Only)

Texas Health Steps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Texas Health Steps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible members who are from birth through 20 years of age. Texas Health Steps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations.

Texas Health Steps' designated staff (Texas Department of State Health Services [DSHS], Department of Assistive and Disability Services [DADS], or contractor), through outreach and informing, encourage eligible children to use Texas Health Steps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Please refer to the Texas Medicaid Provider Procedures Manual for more information regarding Texas Health Steps dental services:

Go to www.tmhp.com. Click on "Providers" at the top of the screen, then "Reference Material" on the left hand side.

Texas Health Steps Medical Checkup Periodicity Schedule for Infant, Children, and Adolescents

Current Dental Terminology © American Dental Association. All Rights Reserved.

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* BIRTH THROUGH 10 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.

AGE	History	Nutritional Screening	DEVELOPMENTAL SURVEILLANCE: Review of Milestones	DEVELOPMENTAL SURVEILLANCE: ASQ, ASQ:SE, or PEDS	DEVELOPMENTAL SURVEILLANCE: M-CHAT or M-CHAT-R/F™	MENTAL HEALTH: Mental Health: Psychosocial/ Behavioral Health Screening	MENTAL HEALTH: Postpartum Depression Screening	TB Questionnaire with Skin Test if Risk Identified	Undothed Physical Examination	Critical Congenital Heart Defect Screening	MEASUREMENTS: Length	MEASUREMENTS: Height	MEASUREMENTS: Weight	MEASUREMENTS: BMI	MEASUREMENTS: Fronto-Occipital Circumference	MEASUREMENTS: Blood Pressure	VISION: Visual Acuity	VISION: Subjective Vision	HEARING: Newborn Hearing Test (OAE or ABR)	HEARING: Audiometric Screening	HEARING: Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	LABORATORY TESTS: Newborn Screening Panel	LABORATORY TESTS: Blood Lead Screening	LABORATORY TESTS: Anemia	LABORATORY TESTS: Dyslipidemia	LABORATORY TESTS: Type 2 Diabetes	Health Education/Anticipatory Guidance
Newborn	■	■	■			■	▒		■	■	■		■		■			■	■				■	■					■
D/C to 5 days	■	■	■			■	▒		■	▒	■		■		■			■	▒		■		■	▒					■
2 weeks	■	■	■			■	▒		■		■		■		■			■			■		■	▒					■
Months 2	■	■	■			■	▒		■		■		■		■			■			■		■	▒					■
Months 4	■	■	■			■	▒		■		■		■		■			■			■		■	▒					■
Months 6	■	■	■			■	▒		■		■		■		■			■			■	■	■	▒					■
Months 9	■	■		■		■	▒		■		■		■		■			■			■	▒	■						■
Months 12	■	■	■	▒		■	▒	■	■		■		■		■			■			■	■	■		■	■			■
Months 15	■	■				■	▒	▒	■		■		■		■			■			■	▒	■		▒	▒			■
Months 18	■	■		■	■	■	▒	▒	■		■		■		■			■			■	■	■		▒				■
Months 24	■	■		■	■	■	▒	■	■		■		■	■	■			■			■	■	■		■				■
Months 30	■	■	■	▒	▒	■	▒	▒	■		■		■	■	■			■			■	■	■		▒		■		■
Years 3	■	■		■		■	▒	■	■			■	■	■	■	■	■				■	■	■		▒		■		■
Years 4	■	■		■		■	▒	■	■			■	■	■	■	■	■		■		■	■	■		▒		■		■
Years 5	■	■	■	▒		■	▒	■	■			■	■	■	■	■	■		■		■	■	■		▒		■		■
Years 6	■	■	■			■	▒	■	■			■	■	■	■	■	■		■		■	■	■		▒		■		■
Years 7	■	■				■	▒	■	■			■	■	■	■	■	▒	■	▒	■	■	■	■				■		■
Years 8	■	■				■	▒	■	■			■	■	■	■	■	■		■		■	■	■				■		■
Years 9	■	■				■	▒	■	■			■	■	■	■	■	▒	■	▒	■	■	■	■				■		■
Years 10	■	■				■	▒	■	■			■	■	■	■	■	■		■		■	■	■				▒	▒	■

LEGEND

- ■ Mandatory
- ▒ If not completed at the required age, must be completed at the first opportunity if age appropriate.
- ■▒ For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- Recommended
- Risk-based

E03-13634 July 1, 2018

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/. For free online provider education: txhealthsteps.com.

TEXAS Health and Human Services
Texas Health Steps

Current Dental Terminology © American Dental Association. All Rights Reserved.

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents

COMPREHENSIVE HEALTH SCREENING* 11 THROUGH 20 YEARS OF AGE

* Comprehensive Health Screening, as indicated below, consists of federal and state components that are required for the checkup to be considered complete. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for further detail at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Find current Periodicity Schedule online at http://www.dshs.state.tx.us/thsteps/providers.shtm.

			MENTAL HEALTH				MEASUREMENTS				VISION		HEARING				LABORATORY TESTS				
AGE	History	Nutritional Screening	Mental Health: Psychosocial/ Behavioral Health Screening	PSC-17, PSC-35, Y-PSC, PHQ-9, PHQ-A, CRAFFT, or Patient Health Questionnaire for Adolescents	TB Questionnaire with Skin Test if Risk Identified	Unclothed Physical Examination	Height	Weight	BMI	Blood Pressure	Visual Acuity	Subjective Vision	Audiometric Screening	Subjective Hearing	Dental Referral	Screen/Administer Immunizations According to ACIP Guidelines	Dyslipidemia	Type 2 Diabetes	STD/STI Screening	HIV Test	Health Education/Anticipatory Guidance
Years 11	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
12	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■
13	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
14	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
15	■	■	■	■	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■
16	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
17	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
18	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
19	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
20	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

LEGEND

- ■ Mandatory
- ■ If not completed at the required age, must be completed at the first opportunity if age appropriate.
- ■■ For developmental, mental health, vision, or hearing screenings: when both colors appear at the same age, perform the most appropriate-level screen.
- ■ Recommended
- ■ Risk-based

Note: THSteps components may be performed at other ages if medically necessary. Check regularly for updates to this schedule: http://www.dshs.texas.gov/thsteps/Texas-Health-Steps-Checkup-Components/. For free online provider education: txhealthsteps.com.

E03-13634 July 1, 2018

TEXAS Health and Human Services
Texas Health Steps

Exception to Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services For Texas Health Steps Dental Procedures

Oral evaluations and dental checkups allow for the early diagnosis and treatment of dental problems. They might be needed at more frequent intervals than noted in the periodicity schedule.

If needed, a dental checkup or oral evaluation can still be reimbursed when the service falls outside the periodicity schedule. The rules for such exceptions are outlined below.

Exception-to-Periodicity Oral Evaluation

A Texas Health Steps exception-to-periodicity oral evaluation is limited to dental procedure code D0120.

An exception-to-periodicity oral evaluation is allowed when the service is:

- Medically necessary and based on risk factors and health needs for members birth through 6 months of age.
- Mandated service required to meet federal or state exam requirements for Head Start, daycare, foster care or preadoption.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Providers must include all appropriate procedure codes on the dental claim submission form. Providers would need to include a narrative and comment in box 35.

Exception-to-Periodicity Dental Checkup

A Texas Health Steps exception-to-periodicity dental checkup is allowed when:

- The member will not be available for the next periodically due dental checkup. This includes members whose parents are migrant or seasonal workers.
- For members whose parents are migrant or seasonal workers and need the accelerated services, include “Exception” in block 35, “Remark” field.

Providers must include all appropriate procedure codes on the dental claim submission form.

Exception-to-Periodicity Emergency or Trauma Related Oral Evaluation

A Texas Health Steps exception-to-periodicity emergency or trauma related oral evaluation is limited to dental procedure code D0140.

Procedure code D0140 is limited to once per day for the same provider and twice per day for any provider.

A Texas Health Steps exception-to-periodicity emergency or trauma related dental service will be allowed when the service is:

- Required for immediate treatment and any follow-up treatment.
- Required for therapeutic services needed to complete a case for members, 5 months of age and younger, when initiated as emergency services, trauma, or early childhood caries.

When submitting a claim for emergency or trauma related dental services, the provider must include:

- “Trauma” or “Emergency” in Block 35, “Remark” field
- The original date of treatment or incident in Block 35, “Remark” field

Providers must include all appropriate procedure codes on the dental claim submission form.

Adjunctive General Services

When submitting a claim for an unclassified treatment procedure code D9110 the provider must include:

- “Trauma” or “Emergency” in Block 35, “Remark” field
- The original date of treatment or incident in Block 35, “Remark” field

Providers must include all appropriate procedure codes on the dental claim submission form.

Children of Migrant Farmworkers

Current Dental Terminology © American Dental Association. All Rights Reserved.

Children of Migrant Farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Providers must include all appropriate procedure codes on the dental claim along with "Exception" & "FWC or Farm Worker Child" in Block 35, "Remark" field.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Children's Medicaid Dental Covered Services

Texas Medicaid Dental Program benefits are subject to the same benefit limits and exclusions that apply to Traditional Medicaid, but are not subject to the maximum fees imposed under Traditional Medicaid. For a complete list of the limitations and exclusions that apply to each Medicaid benefit category, refer to the current ***Texas Medicaid Provider Procedures Manual (TMPPM)***, which can be accessed online at: http://www.tmhp.com For informational purposes only, the maximum fees for Traditional Medicaid are located in the Texas Medicaid Fee Schedule in the *TMPPM* and online at http://public.tmhp.com/FeeSchedules/Default.aspx

The following is a non-exhaustive, high-level list of Covered Services in the Texas Medicaid Dental Program. Covered Services are subject to modification based on changes in federal and state laws, rules, regulations, and policies.

Texas Medicaid Dental Program Covered Services include the following Medically Necessary services.

- Diagnostic and preventive
- Therapeutic
- Restorative
- Endodontic
- Periodontal
- Prosthodontic (removable and fixed)
- Implant and oral and maxillofacial surgery
- Orthodontic
- Adjunctive general

CHIP Dental Covered Services

Covered Dental Services are subject to a $564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.

Current Dental Terminology © American Dental Association. All Rights Reserved.

CHIP Members who have exhausted the $564 annual benefit limit continue to receive the following Covered Dental Services in excess of the $564 annual benefit maximum:

(1) The diagnostic and preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule; and

(2) Other Medically Necessary Covered Dental Services approved by the Dental Contractor through a prior authorization process. These services must be necessary to allow a CHIP Member to return to normal, pain and infection-free oral functioning. Typically, this includes:

- Services related to the relief of significant pain or to eliminate acute infection;
- Services that allow the CHIP Member to attain the basic human functions (e.g., eating, speech); and
- Services that prevent a condition from seriously jeopardizing the CHIP Member's health/functioning or deteriorating in an imminent timeframe to a more serious and costly dental problem.

Texas CHIP Dental Program Covered Services include the following Medically Necessary services.

- Diagnostic and preventive
- Therapeutic
- Restorative
- Endodontic
- Periodontal
- Prosthodontic
- Oral and maxillofacial surgery

Note: If a Member is undergoing a course of treatment, the Covered Services terminate on the Date of Disenrollment.

Refer to the most recent version of the *Code on Dental Procedures and Nomenclature* for coding that applies to Covered Dental Services.

C. Quality Management

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 practice guidelines to dental managed care. The Quality Improvement Program includes but is not limited to:

- Provider credentialing and re-credentialing.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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 1-800-896-2374 or via e-mail at:

denelig.benefits@dentaquest.com

Utilization Management Program (Policies 500 Series)

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.

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

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.
- Treatment cost effectiveness.

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.

D. Provider Responsibilities

General Responsibilities

Availability and Accessibility

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 Members sometimes fail to show up for appointments.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Members should have the ability to receive direction from their provider on how to obtain emergency services 24 hours a day, 7 days per week, including holidays and vacations. Emergency appointments should be scheduled within 24 hours. The patient should be informed that only the emergent condition will be treated at that time.

Members should not wait for more than fifteen (15) to thirty (30) minutes beyond their appointment time to begin their dental care. If the wait time goes beyond this period, an explanation for the delay should be given to the Member and/or Member’s representative, with the option to reschedule the appointment.

Main Dental Home Responsibilities

Texas defines a Main Dental Home as the dental provider who supports an ongoing relationship with the member that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a member’s Main Dental Home, begins no later than six (6) months of age and includes referrals to dental specialists when appropriate.

The Dental Contractor must develop a network of Main Dental Home Providers, consisting of Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists, who will provide preventative care and refer Members for specialty care as needed.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry, Main Dental Home Providers must perform a caries risk assessment as part of the comprehensive oral examination. Main Dental Home Providers must bill one of the following caries risk assessment codes: D0601, D0602, or D0603 with every comprehensive oral examination (D0150), oral examination for a patient under 3 years of age (D0145), or periodic dental evaluation (D0120). These risk codes will be included as part of an informational component of the D0150, D0145 or D0120 billing code and do not have a separate rate attached to them. Claim will reject when any of the following codes D0150, D0145 or D0120 are submitted without a caries risk assessment code. Providers will be given the standard 120-day appeal period for the denied claim to submit proof of performing a caries risk assessment.

The TMPPM and the MMC-CHIP Dental Provider Manual is effective with this change as of October 1, 2015.

First Dental Home Initiative Responsibilities

In addition to establishing a Network of Main Dental Home Providers, the Dental Contractor

Current Dental Terminology © American Dental Association. All Rights Reserved.

must implement a “First Dental Home Initiative” for Medicaid Members. This initiative will enhance dental providers’ ability to assist Members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as 6 months of age and must include the following:

- Comprehensive oral examination;
- Oral hygiene instruction with primary caregiver;
- Dental prophylaxis, if appropriate;
- Topical fluoride varnish application when teeth are present;
- Caries risk assessment; and
- Dental anticipatory guidance as defined in the Texas Medicaid Provider Procedures Manual (TMPPM), Volume 2, Children's Services Handbook and requires documentation of the specific information conveyed to the parent/guardian for at least 3 of the 8 anticipatory guidance topics found in the handbook.

Medicaid Members from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every sixty (60) days if Medically Necessary.

Providers must be certified to be a Texas Health Steps Dentist. To become a First Dental Home Initiative Provider (Texas Health Steps), the dentist must complete either the online module or in-person training and submit registration information.

Only certified, participating First Dental Home Providers may bill a D0145 for a first dental home oral evaluation. The member is only allowed one of D0120 or D0150 in a six month period. D1330, D1206, and D1208 will be denied when billed on the same date of service as D0145.

Updates to Contact Information

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 Members only), office hours, and any other panel limitations that DentaQuest is aware of, such as patient age minimum and maximum, etc. The online provider directory reflects the most current information.

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 1-800-896-2374 to report any changes.

Plan Termination

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Referral to Specialists Process

Referrals to Specialists

Main Dental Home Providers must assess the dental needs of Members for referral to specialty care providers and provide referrals as needed. Main Dental Home Providers must coordinate Member's care with specialty care providers after referral.

Routine preventative care referrals must be provided within 30 days of request.

Texas Medicaid and CHIP Dental Services Members do not require authorization to see a dental specialist. However, only services provided by a Contracting Dentist are covered by DentaQuest, therefore a Texas Medicaid or CHIP Dental Services Member must be treated by a dentist enrolled in the Texas Medicaid or CHIP Dental Services. 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 Texas Medicaid or CHIP Dental Services 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 at 1-800-896-2374 to facilitate a Member referral to a Specialist.

Referrals from a Main Dentist to General Dentist/Pedodontist for Interim Care Also known as the "Texas Interim Care Transfer (ICT) Process"

This process is to be utilized when a Main Dentist Dental Home Provider (Main Dentist) determines that it is necessary for another Main Dentist (general or pediatric dentist) to provide interim care to a Member; yet the Main Dentist assignment should be maintained. The Interim Care Transfer Form will need to be filled out only if other Main Dentist is at a location different than Main Dentist Dental Home Provider.

A. Main Dentist identifies the need for interim care for a Member.

B. Main Dentist completes the Interim Care Transfer Form (which is available via the web portal and in A-23) with the interim Transfer Provider's (general or pediatric dentist) information and the need for the Member to have services rendered outside the Main Dental Home. Transfer Provider must be in network for claims to be paid.

Current Dental Terminology © American Dental Association. All Rights Reserved.

C. Main Dentist completes the Interim Care Transfer on the portal (provideraccess.dentaquest.com).

D. The approval is valid for 270 days. Both Main Dental Home Provider and Transfer Provider may review the status of the submitted Interim Care Transfer on the portal.

E. Transfer Provider renders services within 270 days (otherwise an extension is required) and submits claim.

F. DentaQuest processes the claim and pays the Transfer Provider.

G. As the Main Dentist, any follow-up and coordination of care is the responsibility of the Main Dentist initiating the Interim Care Transfer.

Verify Member Eligibility and/or Authorizations for Service

Member Eligibility

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Provider Web Portal (located in 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.

If you are having difficulty accessing either the IVR or the Provider Web Portal, please contact the Customer Service department at 1-800-896-2374. They will be able to assist you in utilizing either system.

Access to eligibility information via the Provider Web Portal

DentaQuest's Provider Web Portal currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the 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 TIN and State. If you have not received instruction on how to complete Provider Self Registration, you can access the guide at http://www.dentaquest.com/getattachment/State-Plans/Regions/texas/Dentists-Page/New-Provider-Registration-Tip-Sheet.pdf. If you need further assistance, please contact DentaQuest's Customer Service Department at 1-800-896-2374.

Once logged in, select patient from the portal menus then choose Member eligibility search. You are able to check on an unlimited number of Members 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

1. Call DentaQuest Customer Service at 1-800-896-2374.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. Enter or state your NPI number.
4. Enter or state your last 4 digits of your Tax ID.
5. The system will read back the NPI entered. If correct, press (1); if it needs to be re-entered, press (2).
6. Enter Member ID – contains only numbers, press (1) or say "number"; contains numbers and letters, press (2) or say "letter".
7. Enter Member DOB.
8. The system will read back the DOB entered. If correct, press (1); if it needs to be re-entered, press (2).
9. Multiple options will be given –press the option number that corresponds to the reason for the call.
10. 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 in formation, get limited claim history on this Member, or get fax confirmation of this call.
11. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department at 1-800-896-2374 and press 2 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to check benefit history and/or transfer to a Customer Service Representative to answer any additional questions. Using your telephone keypad, you can request eligibility information on a Medicaid or CHIP Member by entering the Member's recipient identification number and a date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

If eligibility is verified, the dentist may not treat the Member as a private-pay patient to avoid Texas Medicaid or CHIP Dental Services billing, obtaining prior authorization (when necessary) or complying with any other program requirement. In addition, upon obtaining eligibility verification, the dentist cannot bill the Texas Medicaid Dental Services Member for any covered service.

Once eligibility verification has been established, a dentist can decline to treat a Member only under the following circumstances:

- The dentist is unable to provide the particular service(s) that the Member requires.
- The Member is not eligible for dental services.
- The Member is unable to present satisfactory identification.

Current Dental Terminology © American Dental Association. All Rights Reserved.

A dentist who declines to accept a Member must do so before accessing eligibility information except in the above circumstances. If the dentist is unwilling to accept an individual as a patient, the dentist has no authority to access the individual's confidential eligibility information.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. Eligibility is determined by HHSC or its designee(s). The eligibility information provided by DentaQuest to contracting offices reflects the eligibility information received. The Medicaid Member will be covered until his/her name no longer appears on the eligibility information provided to DentaQuest. Therefore, it is vital that providers verify eligibility before initiating treatment to a patient.

Authorizations of Service

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 HHSC 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. Approved authorizations expire after 180 days and Orthodontic authorizations expire after 3 years. Prior authorization is optional for all covered procedures with the exception of all Orthodontic codes (see Review Requirements identified in Exhibits A and B). Non-urgent specialty care should be provided within 60 Days of authorization.

Providers must note that "PA Not Required" is not equivalent to "Medically Necessary". It is not to be assumed that payment will be dispensed for a service that does not require Prior Authorization. Approval of prior authorization does not guarantee payment. The service will still be subject to retrospective review to confirm medical necessity.

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 (Exhibit A and B) to understand the decision making process used to determine payment for services rendered.

A. 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.

B. Pre-Payment Review- Dental procedures that require review by DentaQuest for determination of medical necessity prior to reimbursement for the procedures. These procedures can be administered before determination of medical necessity is rendered but require submission of proper documentation for approval to process the claim.

Your submission of "documentation" should include:

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

Your submission should be sent on a 2018, 2019, or later ADA approved claim form. The tables of Covered Services (Exhibits A and B) contain a column marked "Review Required." A "Yes" in this column indicates that the service listed requires that documentation be submitted with the claim for pre-payment review in order to be considered for reimbursement. The "Documentation Required" column will describe what information is necessary for pre-payment review.

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 four (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 2018, 2019, 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

All radiographs, must be of good diagnostic quality, include member's full name, date films taken, and identify the patients left and right side

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.**

Electronic Attachments

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 1-800-782-5150.

OrthoCAD™ DentaQuest accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. Submissions using **OrthoCAD™ also** require the submission of the form found on page B-5. 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.cadentinc.com or call **OrthoCAD™** at 1-800-577-8767.

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 Texas Medicaid and CHIP Dental Services Members through the maximum sharing of Members' dental records. Within thirty (30) days of a written request by a Texas Medicaid or CHIP Dental Services Member, you must be able to provide copies of the patient's dental records to any other dentist treating such Member.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Texas Medicaid and CHIP Dental Services Members are not subject to limitations or exclusions of covered dental benefits due to a pre-existing condition.

Dental Records

Organization

1. The record must have areas for documentation of the following information:
    a. Registration data including a complete health history.
    b. Medical alert predominantly displayed inside chart jacket.
    c. Initial examination data.
    d. Radiographs.
    e. Periodontal and Occlusal status.
    f. Treatment plan/Alternative treatment plan.
    g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).
2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.
    a. Health history.
    b. Medical alert.
    c. Examination/Recall data.
    d. Periodontal status.
    e. Treatment plan.
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient, (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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:

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 Members.

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).

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 #, surface, quadrant etc.)

    e. Signature of the Provider who rendered the service.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

    a. Patient examination.

    b. Treatment plan.

    c. Treatment status.

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.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT 2009-2010) 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 2018, 2019, 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 1-800-896-2374 or via e-mail at denelig.benefits@dentaquest.com.

Access to Second Opinion

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.

Justification Regarding Out-of-Network 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

Informed Consent for Utilization of Papoose Boards

Written and informed consent from a legal guardian must be obtained and documented in the patient record prior to protective stabilization. The patient's record must include:

- Informed consent (should occur on a day separate from the treatment, if possible)
- Type of stabilization used
- Indication for stabilization
- Behavior during stabilization
- Any untoward outcomes, i.e. skin markings
- The duration of the application

Indications*

- A previously cooperative patient quickly becomes uncooperative during the appointment in order to protect the patient's safety and expedite completion of the treatment

Contradictions**

- Patient's with a history of psychological trauma due to restraint (unless no other alternatives are available)

A parent has the right to terminate restraint at any time. If termination is requested, the practitioner should complete the necessary steps to bring the procedure to a safe conclusion before ending the appointment.
Goals of Behavior Management

- Establish communication.
- Alleviate fear and anxiety.
- Deliver quality dental care.
- Build a trusting relationship between dentist and child.
- Promote the child's positive attitude towards oral/dental health.

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

Dentists must not restrain children without formal training in protective stabilization.

General Dentists should consider referring to dental specialists those Members who they consider to be candidates for protective stabilization.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Dental auxiliaries must not use restraining devices to stabilize children.

1. **Routine use of restraining devices to stabilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**
2. **Dentists must not restrain children without formal training in protective stabilization.**
3. **General dentists should consider referring to dental specialists those Members who they consider to be candidates for protective stabilization.**
4. **Dental auxiliaries must not use restraining devices to immobilize children.**

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

2013 AAPD Clinical Guidelines on Protective Stabilization for Pediatric Dental Patients
**Tennessee Board of Dentistry Newsletter. Spring 2004

Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services

Definitions

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

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Requirements for Scheduling of Appointments

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:

- Preventive – 14 calendar days.
- Therapeutic/diagnostic- 14 calendar days.
- Urgent- 24 hours.

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); and
4. Health and Human Services Commission's Medical Transportation.

Either the Member's medical plan or HHSC's claims administrator will pay for treatment and 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 of 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.

MEDICAL TRANSPORTATION PROGRAM (MTP)

What is MTP?

Current Dental Terminology © American Dental Association. All Rights Reserved.

MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid members who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- Mileage reimbursement for a registered individual transportation participant (ITP) or a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or member.
- Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
- Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the member to a healthcare service)
- Advanced funds to cover authorized transportation services prior to travel

Call MTP:

For more information about services offered by MTP, members, advocates and providers can call the toll free line at 1-877-633-8747. In order to be transferred to the appropriate transportation provider, members are asked to have either their Medicaid ID# or zip code available at the time of the call.

CHIP Services Not Covered by DentaQuest

Some services are paid by CHIP medical plans instead of DentaQuest. These services include treatment and devices for craniofacial anomalies, and 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 of 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.

Effective January 1, 2019 - Retro eligibility Recoupment Process

Current Dental Terminology © American Dental Association. All Rights Reserved.

Funds will be recouped from paid claims with dates of service on or after January 1, 2019 where the member's eligibility has been retro-actively terminated. All decisions with regards to payment are subject to appeal. You may appeal our handling of payment by submitting a written request for review to HHSC.

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the member name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:
Texas Health and Human Services Commission HHSC Claims Administrator Contract Management
Mail Code-91X P.O. Box 204077
Austin, Texas 78720-4077

E. Medicaid Dental Services Provider Complaint and Appeal Process

Medicaid Provider Complaints

Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Complaints must be resolved within thirty (30) calendar days. If a complaint cannot be resolved within thirty (30) days, the provider will be notified in writing the status of the complaint. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

Complaints to DentaQuest may be submitted using the following methods:

(Non-claim related) • By telephone at 1-800-896-2374

(Claim related) • In writing to:

Current Dental Terminology © American Dental Association. All Rights Reserved.

DentaQuest- TX Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

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

Medicaid complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H-320
PO Box 85200
Austin, Texas 78708

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

Medicaid Provider Appeals

For appealed claims, Providers must submit all appeals of denied claims and requests for adjustments on paid claims within **one hundred and twenty (120) days** from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record. Appeals should be mailed to:

DentaQuest TX HHSC Dental Services
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

We will respond to the appeal within thirty (30) calendar days after we receive the request with any necessary supporting documentation.

Peer to Peer Reviews

If you have a question or concern regarding any determination, you may speak with a dental director during regular business hours, by calling the Provider Services line at 1-800-896-2374. Clinical review guidelines used in all determinations will be provided in writing, upon request.

F. Medicaid Dental Services Member Complaint and Appeal

Current Dental Terminology © American Dental Association. All Rights Reserved.

Process

Medicaid Member Complaint

The Member receives the following information as it pertains to Medicaid Member Complaints:

A Medicaid Member 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 toll-free at 1-800-516-0165 to tell us about your problem. A DentaQuest Member Advocate can help you file a complaint. Just call 1-800-516-0165. 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- TX HHSC Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

Once we receive your complaint, DentaQuest will acknowledge your complaint within five (5) business days of receipt. We will respond within thirty (30) calendar days of receipt of your complaint.

The resolution letter will:

1. Explain the resolution of the complaint.
2. State the specific dental and contractual reasons for the resolution.
3. State the specialization of any dentist or other Provider consulted.
4. Include a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

If the Member is not satisfied with the outcome, who else can they call?

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 A.M. – 5P.M., Monday - Friday. If you have a hearing disability, call the toll-free Relay Texas service at 7-1-1 or 1-800-735-2389. If you would like to make your complaint in writing, please send it to the following address:

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

Fax: 888-780-8099

If you can get on the Internet, you can access more information here:

Online: https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-managed-care-help

Medicaid Member Appeals

The Member receives the following information as it pertains to Medicaid Member Appeals:

A Medicaid Member Appeal is the formal process by which a Member or his or her representative requests 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) 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

Non-emergency appeals will be processed within thirty (30) calendar days from the day we receive it.

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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. The Member has the right to request an appeal for denial of payment for service in whole or in part.

To ensure continuation of currently authorized services, the Member must file the appeal on or before the later of: ten (10) business 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.

Can someone from DentaQuest help a Member file an appeal?

Yes. A DentaQuest Member Advocate can help the Member file an appeal. Just call 1-800-516-0165.

The Member also has the option to file for a State Fair Hearing after DentaQuest's appeal process has been exhausted.

Medicaid Member Expedited Appeals

The Member receives the following information as it pertains to Medicaid Member Expedited Appeals:

How to Request an Expedited Appeal

If you have an emergency appeal, you can call us at 1-800-516-0165. Call and tell us you need an expedited appeal. A request for an expedited appeal can be made orally or in writing.

Timeframes for Expedited Appeals

We will respond within three (3) business days from the day we receive your request for appeal.

What happens if DentaQuest denies the request for an Expedited Appeal?

If DentaQuest does not think the appeal is life-threatening, the Member will be notified the same day that the decision is made. The appeal will still be worked on, but the decision may take up to thirty (30) days.

Who can help me file an Expedited Appeal?

If you need help filing an expedited appeal, call us toll-free at 1-800-516-0165, and a DentaQuest Member Advocate will help you.

Current Dental Terminology © American Dental Association. All Rights Reserved.

State Fair Hearing Information

Can a Member ask for a State Fair Hearing?

If the Member of the health plan disagrees with the health plan's decision, the Member has the right to ask for a fair hearing. The Member may name someone to represent him/her by writing a letter to the health plan telling the MCO the name of the person he/she wants to represent him or her. A provider may be the Member's representative. The Member or Member's representative must ask for the fair hearing within one-hundred and twenty (120) days of the date on the health plan's letter that tells of the decision that is being challenged. If the fair hearing isn't requested within one-hundred and twenty (120) days, the Member may lose their right to a fair hearing. To ask for a fair hearing, the Member or Member's representative should either send a letter to the health plan at:

DentaQuest-TX Dental Program
Attn: Fair Hearing Coordinator
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

Or call: 1-800-516-0165

If the fair hearing is requested within ten (10) business days from the time the hearing notice is received from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the request is not made within ten

(10) days from the time the hearing notice is received, the service the health plan denied will be stopped.

When the Member or Member's representative requests a fair hearing, they will get a packet of information with the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or Member's representative can tell why the service the health plan denied is needed.

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

G. CHIP Provider Complaints and Appeals

CHIP Provider Complaints

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

Complaints to DentaQuest may be submitted using the following methods:

(Non-claim related) • By telephone at 1-800-896-2374

(Claim related) • In writing to:

DentaQuest- TX Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

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

CHIP complaint requests may be mailed to the following address:

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091.

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

CHIP Provider Appeals

For appealed claims, Providers must submit all appeals of denied claims and requests for adjustments on paid claims within **one hundred and twenty (120) days** from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared.

The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

Appeals should be mailed to:

DentaQuest TX HHSC Dental Services
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

Current Dental Terminology © American Dental Association. All Rights Reserved.

We will respond to the appeal within thirty (30) calendar days after we receive the request with any necessary supporting documentation.

Peer to Peer Reviews

If you have a question or concern regarding any determination, you may speak with a dental director during regular business hours, by calling the Provider Services line at 1-800-896-2374. Clinical review guidelines used in all determinations will be provided in writing, upon request.

"Like Specialty" Peer to Peer Reviews

Like Specialty Peer-to-Peer Process: DentaQuest's internal process where the Provider disagrees with DentaQuest's claim appeal's decision based on Medical Necessity and requests a "like specialty" Peer-to-Peer discussion with a Dental Director. The Dental Director resolving the dispute must hold the same specialty or a related specialty as the appealing Provider and is not the Dental Director that was involved in any previous determinations. The Dental Director completing the "like specialty" peer to peer discussions is a non-network provider.

Procedure

Requesting a "like specialty" Peer-to-Peer discussion

1. Upon completion of an appeal relating to claims payment, if the appealing Provider disagrees with the appeal decision; they have the right to request a "like specialty" peer-to-peer discussion with a Specialist within 30 days from the appeal disposition of an adverse determination. This process applies only when:
    a. The services in question have already been rendered;
    b. The Provider dispute is related to denial on the basis of Medical Necessity; and
    c. The Provider has completed the appeal process and received the appeal determination.
2. Peer-to-Peer like-specialty meeting requests can be submitted verbally or in writing. The Provider may contact DentaQuest's Provider Call Center's toll free number at 800.896.2374 or may submit a written request to DentaQuest's Complaints & Appeals Department at the following address:

    DentaQuest
    Attn: Complaints & Appeals
    Stratum Executive Center
    11044 Research Blvd
    Building D, Suite D-400
    Austin, TX 78759

3. Peer-to-Peer requests are handled by the Complaint and Appeals Specialist (C&G Specialist) and the resolution coordinated with Dental Directors and other areas

Current Dental Terminology © American Dental Association. All Rights Reserved.

within DentaQuest. Non-participating Consultants of a similar specialty as the Provider will be contracted by DentaQuest to resolve claim disputes related to denial on the basis of Medical Necessity that remain unresolved subsequent to a provider appeal.

4. Upon the receipt of the Peer-to-Peer request, the Complaints and Grievance Specialist contacts the Provider within five (5) days from the receipt. The provider will be contacted via email or phone, based on the provider's preference.

5. The C&G Specialists will schedule a conference between the Provider and the Consultant within two weeks, or as soon as the Provider and Consultant's schedules permit.

6. The C&G Specialist will provide all records related to the case to the Consultant in advance to the scheduled conference. DentaQuest's Clinical Guidelines which incorporates the guidelines from: American Dental Association, the American Pediatric Dental Association, the Medicaid Program and any contract specific related items will be included. These guidelines are used as a reference and taken into consideration for each individual case. These guidelines are available upon request.

Resolution of "like-specialty" peer-to-peer discussion

1. Upon completion of the like-specialty peer-to-peer conference, the Consultant will communicate the decision via fax or e-mail to the C&G Specialist.

2. The C&G Specialists will document the Consultant's decision and relevant information in the C&G Module.

3. The Consultant's decision is binding on DentaQuest and the Provider.

4. A resolution to the Provider will be rendered and written communication is sent to the Provider within two business days from completion of the like-specialty discussion.

CHIP Member Complaints and Appeals

CHIP Member Complaint

The Member receives the following information as it pertains to CHIP Member Complaints:

A CHIP Member Complaint is any dissatisfaction, expressed by a Complainant, orally or in writing, to DentaQuest, with any aspect of DentaQuest's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to Medical Necessity; and the way a service is provided. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Current Dental Terminology © American Dental Association. All Rights Reserved.

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at 1-800-508-6775 to tell us about your problem. A DentaQuest Member Services Advocate can help you file a complaint.

You can also send your complaint in writing to:

DentaQuest- TX HHSC Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

Who do I call?

Just call 1-800-508-6775. Most of the time, we can help you right away or at the most within a few days.

Can someone from DentaQuest help a Member file a complaint?

Yes. A DentaQuest Member Advocate can help the Member file a complaint. Just call 1-800- 508-6775.

How long will it take to investigate and resolve my complaint?

Once we receive your complaint, DentaQuest will acknowledge your complaint within five (5) business days of receipt. We will respond within thirty (30) calendar days of receipt of your complaint.

The resolution letter will:

1. Explain the resolution of the complaint.
2. State the specific dental and contractual reasons for the resolution.
3. State the specialization of any dentist or other Provider consulted.
4. Include a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

If I am not satisfied with the outcome, who else can I call?

Any Member, including a Member who has attempted to resolve a complaint through the complaint process described above, may file a complaint with:

Current Dental Terminology © American Dental Association. All Rights Reserved.

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091

The Department's toll-free telephone number is 1-800-252-3439.

The commissioner will investigate a complaint against us to determine our compliance with the insurance laws within sixty (60) days after the Department receives the complaint and all information necessary for the Department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

a. Additional information is needed.
b. An on-site review is necessary.
c. We, the Provider, or the complainant do not provide all documentation necessary to complete the investigation.
d. Other circumstances beyond the control of the Department occur.

We will not engage in any retaliatory action (including termination or refusal to renew a Contract) against a Member or a dentist (on behalf of a Member) for filing a complaint or appealing a decision.

CHIP Member Appeal

The Member receives the following information as it pertains to CHIP Member Appeals:

A CHIP Member Appeal is the formal process by which DentaQuest addresses Adverse Determinations.

What can I do if DentaQuest denies or limits my patient'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.

How will I find out if the appeal is denied?

We will send a written resolution of the appeal within thirty (30) calendar days after receipt of an appeal. Investigation and resolution of appeals involving ongoing Emergency Dental Services will be concluded in accordance with the dental immediacy of the case, but no later than 24 hours after receipt of request for appeal. At the request of the Member, we will provide, instead of an appeal panel, a Provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the procedure or treatment under appeal.

Current Dental Terminology © American Dental Association. All Rights Reserved.

The Provider reviewing the appeal may interview the Member or the Member's designated representative and will make a decision on the appeal. Initial notice of decision of the appeal may be delivered orally, but will be followed by a written notice of the determination within three days.

Notice of our final decision will include a statement of the specific clinical and/or Contract provision(s) on which the decision was based, and the toll-free telephone number and address for MAXIMUS.

Timeframes for the Appeal Process

Non-emergency appeals will be processed within thirty (30) calendar days from the day we receive it.

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

When does a Member have the right to request an appeal?

In the event a Member is not satisfied with our resolution of a complaint, other than issues relating to a Member's annual maximum or eligibility information provided to DentaQuest by Texas HHSC or its designee, he/she will have the right to appeal the decision. A Member also has the right to appeal any adverse decision including denial of payment for services in whole or in part. A 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.

A Member may call DentaQuest to request an appeal. Within five (5) business days after the Member calls, we will send them an appeal form. We must receive the Member's completed, signed appeal form to confirm their appeal request, unless an expedited appeal is requested. 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. (If the appeal request is related to a dental emergency, we do not need a completed, signed form to process the appeal.)

After we receive the written request for an appeal, we will send the Member a letter within five (5) business days. The letter will explain the Member's right to:

- Submit a written appeal to an appeal panel or appear before an appeal panel in person.
- Present information to help the Member's.
- Ask questions about the decision we made regarding the complaint.

No later than five (5) business days before the appeal panel meets, we will send the Member:

- Copies of any documents that the appeal panel will review.
- The specialty field of any dentists who helped us review your case.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- Information about the Members of the appeal panel.

We may tell you the outcome of your appeal right away. We will always send you a written letter of the decision within three (3) business days.

The letter will include:

- Our decision about your appeal.
- The reasons for our decision.
- Contact information for MAXIMUS.

Can someone from DentaQuest help the Member file an appeal?

Please have the Member call our Member Call Center toll-free at 1-800-508-6775 for help in filing an appeal.

CHIP Member Expedited Appeals

The Member receives the following information as it pertains to CHIP Member Expedited Appeals:

How to Request an Expedited Appeal

If you have an emergency appeal, you can call us at 1-800-516-0165. Call and tell us you need an expedited appeal. A request for an expedited appeal can be made orally or in writing.

Timeframes for Expedited Appeals

We will respond within three (3) business days from the day we receive your request for appeal.

What happens if DentaQuest denies the request for an Expedited Appeal?

If DentaQuest does not think the appeal is life-threatening, the Member will be notified the same day that the decision is made. The appeal will still be worked on, but the decision may take up to thirty (30) days.

Who can help me file an Expedited Appeal?

If you need help filing an expedited appeal, call us toll-free at 1-800-516-0165, and a DentaQuest Member Advocate will help you.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Independent Review Organization (IRO) for External CHIP Appeal Reviews

What is an Independent Review Organization?

The purpose of an Independent Review Organization (IRO) is to provide an independent review of health care services that are denied by certain entities, on the basis that the services are not medically necessary or appropriate, or are experimental, or investigational. These entities include Utilization Review Agents, Health Maintenance Organizations, Insurance Carriers, and Certified Workers' Compensation Networks.

How do I request a review by an Independent Review Organization?

If a CHIP Member, a representative designated by a Member, or their Dentist has sent an appeal request to DentaQuest and it was denied, they may be able to have their request for medically necessary services evaluated by DentaQuest's contracted IRO, MAXIMUS, as part of an External Review. This evaluation is processed by MAXIMUS at no cost to the Member.

MAXIMUS must receive the completed HHS-Administered Federal External Review Request Form within four months of the date that DentaQuest sent you a final decision denying your services or your claim for payment. You will be asked to describe the dental services that were denied by DentaQuest and state the reason that you believe DentaQuest's decision was not correct.

HHS-Administered Federal External Review Request Form

https://externalappeal.cms.gov/ferpportal/public/docs/ExtReviewReqInfoForm_20181031.pdf

HHS Federal External Review Process Appointment of Representative Form

https://externalappeal.cms.gov/ferpportal/public/docs/Appointment%20of%20Representative%2 0Form.pdf

MAXIMUS Federal Services will use the information you provide on this form to get the relevant information and documents from DentaQuest. You may add supporting information and documents you think DentaQuest may not be able to provide.

For example, you may choose to provide MAXIMUS with:

- Documents to support the claim, such as dentist's letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to DentaQuest about the claim
- Letters that DentaQuest sent to you about the claim

You do not have to give MAXIMUS this additional information. However, if you do not provide any additional information, MAXIMUS Federal Services may decide your case based only on the information DentaQuest gives us.

Current Dental Terminology © American Dental Association. All Rights Reserved.

You can give MAXIMUS additional information for your external review by sending it with this form in the below options.

Mail to: HHS Federal External Review Request, MAXIMUS
Federal Services,
3750 Monroe Avenue, Suite 705,
Pittsford, NY 14534.

Fax to: 1-888-866-6190

If you have questions about your external review, call MAXIMUS at 1-888-866-6205.

How long will it take to investigate and resolve my external appeal?

DentaQuest will immediately be contacted by MAXIMUS after receiving the request for an External Review. DentaQuest will give MAXIMUS all documents and information used to make the internal appeal decision within five (5) business days.

Standard External Review requests:

The Member or Member's representative will receive written notice of the final External Review decision no later than 45 days after MAXIMUS receives the request for an External Review or as soon as the review has been completed.

Expedited Independent Review Organization request

In most cases, Members, their representative, or Dentist must complete any mandatory appeals or opportunities for reconsideration offered by DentaQuest before MAXIMUS can do an external review. In urgent situations, MAXIMUS may be able to do a review even if the Member, Member's designated representative, or Dentist have not made all appeals and reconsiderations.

If you believe your situation is urgent, you may ask for an expedited (fast) review. An urgent care situation is one in which the Member's health may be in serious jeopardy or, the Member may have pain that cannot be controlled while awaiting the external review decision.

To ask for an expedited external review:

Submit an online request at https://externalappeal.com
OR Fax this form to 1-888-866-6190
OR Mail this form to:

HHS Federal External Review Request,
MAXIMUS Federal Services,
3750 Monroe Avenue, Suite 705,
Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review

Current Dental Terminology © American Dental Association. All Rights Reserved.

from a medical professional who knows about the Member's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call MAXIMUS at **1-888-866-6205**.

How long will it take to investigate and resolve my expedited external appeal?

For an expedited External Review request:

MAXIMUS will give DentaQuest and the Member or Member's representative the External Review decision no later than within 72 hours of receiving the request.

MAXIMUS will contact the Member or Member's representative by phone and will also send a written version of the decision within 48 hours of that phone call. DentaQuest must take action on the notice if the ruling is in favor of the Member, and provide authorization, or coordinate the services after receiving the External Review decision notice. DentaQuest is bound to comply with the decision of the External Review.

HHSC Oversight

HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Texas CHIP Dental Services Member complaints. The dentist must cooperate in all such HHSC inquiries/investigations.

H. Medicaid Member Eligibility and Added Benefits

Eligibility

The Texas HHSC Medicaid Dental Programs provide dental coverage for children enrolled. Eligibility is determined by the HHSC.

Verifying Eligibility

To verify Member eligibility providers may contact: https://www.yourtexasbenefits.com/

*This site is only to verify Member eligibility, not Main Dental Home assignment.

If Members have questions regarding enrolling in the program or their loss of eligibility, they should be referred to the Enrollment Broker at 1-800-964-2777.

Main Dental Home Verification

Main Dental Home assignment must be verified on the DentaQuest Provider Web Portal (located in the "Providers Only" section of DentaQuest's website at www.dentaquest.com). You may also contact DentaQuest's Customer Service Department at 1-800-896-2374 to verify Main Dental Home assignment.

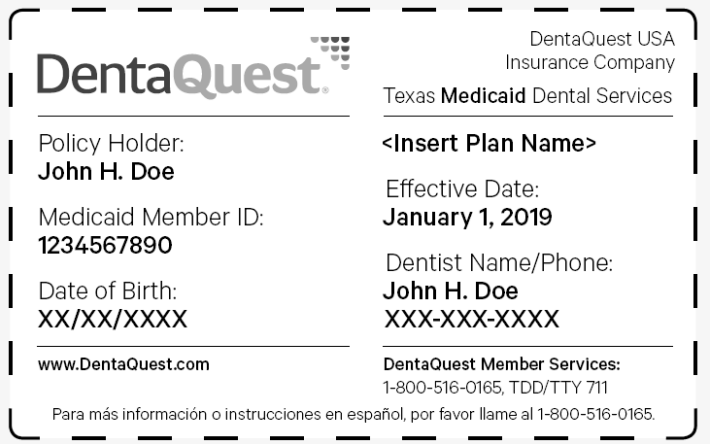
Current Dental Terminology © American Dental Association. All Rights Reserved.

DentaQuest Member Identification Card

Members will receive a DentaQuest TX Medicaid ID Card**.** 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 the DentaQuest USA Medicaid Dental Program 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 identification card is not dated and it does not need to be returned should a Member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the Texas Medicaid Dental Program.**

DentaQuest recommends that providers verify Main Dental Home assignment on the Provider Web Portal prior to treatment, as the Member's assignment may have changed or the Member may be using an old card.

Call DentaQuest

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Provider Web Portal ("Providers Only" section of DentaQuest's website at www.dentaquest.com).

To access the IVR, simply call DentaQuest's Customer Service department at 1-800-896-2374 and press 2 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check.

Automated Inquiry System line/TXMedConnect

This is a provider line responsible for assisting with issues not addressed by other available

Current Dental Terminology © American Dental Association. All Rights Reserved.

provider lines. The Contact Center Representative provides general information concerning the Texas Medicaid Program. The Contact Center is open from 7 a.m. to 7 p.m. Central Time and can be reached at the number listed below:

TMHP Contact Center/Automated Inquiry System (AIS)
1-800-925-9126 or 512-335-5986
www.tmhp.com

Automatic Re-enrollment

If a Member loses Medicaid eligibility and then regains eligibility within six (6) months, the Member is automatically reassigned his previous plan. The Member may choose to switch plans, please see Medicaid Plan Changes below.

Disenrollment

Can DentaQuest ask that my child get dropped from their dental plan?

DentaQuest can ask that a child be removed from their plan for the following reasons:

- The child or the child's caregiver misuses the child's Membership card or loans it to another person,
- The child or the child's caregiver is disruptive, unruly, or uncooperative at the dentist's office, or
- The child or the child's caregiver refuses to follow the dental plan's rules and restrictions.

Neither DentaQuest nor a provider m ay request a disenrollment based on an adverse change in the Member's health or the utilization of services which are medically necessary for the treatment of a Member's condition. A provider cannot take retaliatory action against a Member.

Medicaid Plan Changes

You can change your child's dental plan to another by contacting the Medicaid Enrollment Broker's toll-free telephone number at 1-800-647-6558**.** During the first 90 days after you are enrolled in a dental plan, you can change to another plan for any reason. After 90 days, with a dental plan, you can change to another plan once for any reason. If you show good cause, you can also change dental plans at any time. An example of good cause is that you can't get the care that you need through the dental plan.

If you call to change dental plans on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you ask to change plans on or before April 15, the change will take place on May 1.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- If you ask to change plans after April 15, the change will take place on June 1.

Medicaid Added Benefits

Medicaid Member Value Added Services

DentaQuest is offering value added services to Medicaid Members who receive qualifying services. This chart below tells the Member what treatment he/she must receive to qualify $10 Walmart gift card to promote healthy eating habits, or a dental care kit, which includes a backpack, toothbrush (infant toothbrush for members age 6 months – 35 months and spinning toothbrush for members aged 36 months – 20 years), toothpaste, brushing chart and stickers for the brushing chart.*

Age Range	Required Dental Treatment
Members age 6 – 35 months	Must receive a dental check-up
Members age 36 months – 5 years	Must receive topical fluoride treatment
Members age 6 – 14 years	Must receive sealants from a participating Medicaid Main Dentist
Members age 6 – 9 years	Must have their 1st molars sealed
Members age 10 – 14 years	Must have their 2nd molars sealed
Members age 15 – 20 years	Must have two (2) teeth cleanings

* One dental care kit per eligible member, per lifetime.

Additional value-added services:

Members 6 months – 6 years Members 10 – 13 years	There is treatment that can fix some cavities with no drilling. This treatment is not normally covered under the Medicaid & CHIP programs. If your dentist says you need it to protect you from cavities, you can get it at no cost. Must be prescribed by Main Dentist. Other limitations may apply, please discuss with your Main Dentist.

* One dental care kit per eligible member, per lifetime.

Medicaid Members will receive this information in their Member handbook, along with Instructions on how to receive the dental care kit and/or $10 Walmart gift card. The Member is required to bring the value added services form to your office (see sample below). You will need to put your NPI number and sign the bottom of the form after the Member receives the qualifying services in your office. The Member will mail the completed and signed value added services form to DentaQuest to receive his/her dental care kit and/or Walmart gift card.

Contact DentaQuest provider services at 1-800-896-2374 if you have questions on the value added services program.

I. CHIP Member Eligibility and Added Benefits

Eligibility

Current Dental Terminology © American Dental Association. All Rights Reserved.

The Texas HHSC CHIP Dental Programs provide dental coverage for twelve (12) continuous months for children enrolled.

Verifying Eligibility

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

Eligibility is determined by the HHSC. CHIP Children who enroll in Texas CHIP Dental Services receive twelve (12) months of continuous coverage. Families must re-enroll their children every twelve (12) months.

*This site is only to verify Member eligibility, not Main Dental Home assignment.
If Members have questions regarding enrolling in the program or their loss of eligibility, they should be referred to the Enrollment Broker at 1-800-964-2777.

Main Dental Home Verification

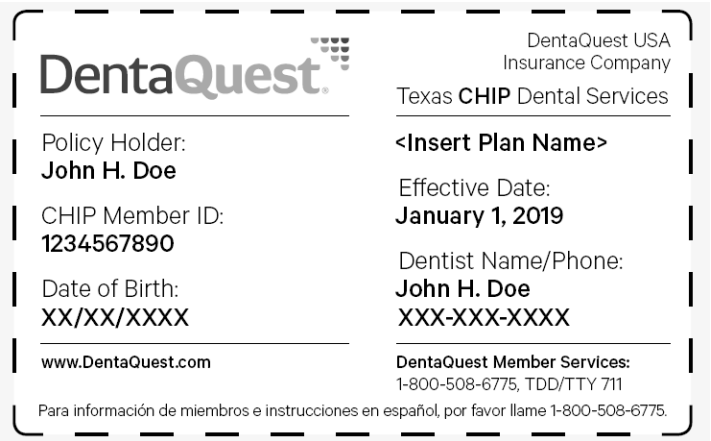
Main Dental Home assignment must be verified on the DentaQuest Provider Web Portal (located in the "Providers Only" section of DentaQuest's website at www.dentaquest.com). You may also contact DentaQuest's Customer Service Department at 1-800-896-2374 to verify Main Dental Home assignment.

DentaQuest CHIP Identification Card

Members will receive a DentaQuest TX CHIP ID Card**.** 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 the DentaQuest USA CHIP Dental Program 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 identification

Current Dental Terminology © American Dental Association. All Rights Reserved.

card is not dated and it does not need to be returned should a Member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the Texas CHIP Dental Program.**

DentaQuest recommends that providers verify Main Dental Home assignment on the Provider Web Portal prior to treatment, as the Member's assignment may have changed or the Member may be using an old card.

Re-enrollment

Families must re-enroll their children in the CHIP Dental Program every twelve (12) months.

Disenrollment

Can DentaQuest ask that my child get dropped from their dental plan?

DentaQuest can ask that a child be removed from their plan for the following reasons:

- The child or the child's caregiver misuses the child's Membership card or loans it to another person.
- The child or the child's caregiver is disruptive, unruly, or uncooperative at the dentist's office.
- The child or the child's caregiver refuses to follow the dental plan's rules and restrictions.

Neither DentaQuest nor a provider may request a disenrollment based on an adverse change in the Member's health or the utilization of services which are medically necessary for the treatment of a Member's condition.

A provider cannot take retaliatory action against a Member.

CHIP Plan Changes

If the child has been in a CHIP dental plan less than ninety (90) days, they can change dental plans. Call CHIP toll-free at 1-800-647-6558.

Members are allowed to make plan changes under the following circumstances:

- For any reason within 90 days of enrollment in CHIP;
- For cause at any time; and
- During the annual re-enrollment period.

The Member's child cannot change dental plans after being in the plan ninety (90) days unless their child is granted an exception for a "good cause." The Member also cannot change dental plans if their child has reached his or her annual dental benefit limit. HHSC will make the final decision.

Current Dental Terminology © American Dental Association. All Rights Reserved.

CHIP Member Value Added Services

DentaQuest is offering value added services to CHIP Members who receive qualifying services. The chart below tells the Member what treatment he/she must receive to qualify for a $10 Walmart gift card to promote healthy eating habits, or a dental care kit, which includes a backpack, toothbrush (infant toothbrush for members aged 6 months – 35 months and spinning toothbrush for members age 36 months – 20 years), toothpaste, brushing chart and stickers for the brushing chart.*

Age Range	Required Dental Treatment
Members age 6 – 35 months	Must receive a dental check-up
Members age 36 months – 5 years	Must receive topical fluoride treatment
Members age 6 – 14 years	Must receive sealants from a participating CHIP Main Dentist
Members age 6 – 9 years	Must have their 1st molars sealed
Members age 10 – 14 years	Must have their 2nd molars sealed
Members age 15 – 18 years	Must have two (2) teeth cleanings

* One dental care kit per eligible member, per lifetime.

Additional value-added services:

Members 6 months – 6 years Members 10 – 13 years	There is treatment that can fix some cavities with no drilling. This treatment is not normally covered under the Medicaid & CHIP programs. If your dentist says you need it to protect you from cavities, you can get it at no cost. Must be prescribed by Main Dentist. Other limitations may apply, please discuss with your Main Dentist.

* One dental care kit per eligible member, per lifetime.

CHIP Members will receive this information in their Member handbook, along with instructions on how to receive the dental care kit and/or $10 Walmart gift card. The Member is required to bring the value added services form to your office (see sample below). You will need to put your NPI number and sign the bottom of the form after the Member receives the qualifying services in your office. The Member will mail the completed and signed value added services form to DentaQuest to receive his/her dental care kit and/or Walmart gift card.

Contact DentaQuest provider services at 1-800-896-2374 if you have questions on the value added services program.

Member Rights and Responsibilities

Current Dental Terminology © American Dental Association. All Rights Reserved.

****The Member receives the following information as it pertains to Member Rights and Responsibilities:**

CHILDREN'S MEDICAID DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITES

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 dental records and discussions with your dentists will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and dentist. You have the right to change to another plan or dentist in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your dental plan and dentist.
    b. Choose any dental plan you want that is available in their area and choose your dentist from that plan.
    c. Change your dentist.
    d. Change your dental plan without penalty.
    e. Be told how to change your dental plan or your dentist.
3. You have the right to ask questions and get answers about anything that you do not understand. That includes the right to:
    a. Have your dentist explain your dental care needs to you and talk to the dentist about the different ways your dental 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 dentist in deciding what dental care is best for you.
    b. Say yes or no to the care recommended by your dentist.
5. You have the right to use each available complaint and appeal process through DentaQuest and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
    a. Make a complaint to DentaQuest or to the state Medicaid program about your dental care, your dentist or your dental plan.
    b. Get a timely answer to your complaint.
    c. Use DentaQuest's appeal process and be told how to use it.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 dental professional 24 hours a day, 7 days a week to get any emergency or urgent care that you need.
   b. Get dental care in a timely manner.
   c. Be able to get in and out of a dental 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 dentist and when talking to your dental 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 DentaQuest plan rules, including the dental care services that you can get and how to get them.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 that you do not want to do, or is to punish you.

8. You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, dental care, and treatment. Before any medically necessary dental services and treatment begin, the services and treatment must be fully explained to you and you must give permission in writing (informed consent). DentaQuest cannot prevent the dentists, hospitals, and others who care for you 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. Dentists, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Medicaid 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 dental plans are available in your area.

2. You must abide by DentaQuest's and Medicaid's policies and procedures. That includes the responsibility to:

    a. Learn and follow DentaQuest's rules and Medicaid rules.

    b. Choose your dental plan and a dentist quickly.

    c. Make any changes in your dental plan and dentist in the ways established by Medicaid and by DentaQuest.

    d. Keep your scheduled appointments.

    e. Cancel appointments in advance when you cannot keep them.

    f. Always contact your dentist first for your non-emergency dental needs.

    g. Be sure that you have approval from your dentist 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 dentist and learn about service and treatment options. That includes the responsibility to:

    a. Tell your dentist about your health.

    b. Talk to your dentist about your dental care needs and ask questions about the different ways your dental care problems can be treated.

    c. Help your dentist get your dental records.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 dental care is best for you.
    b. Understand how the things that you do can affect your dental health.
    c. Do the best that you can to stay healthy.
    d. Treat dentists and staff with respect.

CHIP DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITIES

CHIP Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your dentists and other providers.
2. You have a right to know how your dentists are paid. You have a right to know about what those payments are and how they work.
3. You have a right to know how DentaQuest decides whether a service is covered and/or medically necessary. You have the right to know about the people at DentaQuest who decide those things.
4. You have a right to know the names of the dentists and other providers enrolled with DentaQuest and their addresses.
5. You have a right to pick from a list of dentists that is large enough so that your child can get the right kind of care when your child needs it.
6. You have the right to take part in all the choices about your child's dental care.
7. You have the right to speak for your child in all treatment choices.
8. You have the right to get a second opinion from another dentist enrolled with DentaQuest about what kind of treatment your child needs.
9. You have the right to be treated fairly by DentaQuest, dentists, and other providers.
10. You have the right to talk to your child's dentist and other providers in private, and to have your child's dental records kept private. You have the right to look over and copy your child's dental records and to ask for changes to those records.
11. You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment. DentaQuest cannot prevent dentists, hospitals, and others who care for your child from giving you this information, even if the care or treatment is not a covered service.
12. You have a right to know that you are only responsible for paying allowable copayments for covered services, up to benefit maximum limits. Dentists, hospitals, and others cannot require you to pay any other amounts for covered services.

Current Dental Terminology © American Dental Association. All Rights Reserved.

CHIP Member Responsibilities

The Member and DentaQuest both have an interest in seeing their child's dental health improve. The Member can help by assuming these responsibilities.

1. The Member must try to follow healthy habits. Encourage their child to stay away from tobacco, and to eat a healthy diet.
2. The Member must become involved in the dentist's decisions about their child's treatments.
3. The Member must work together with DentaQuest's dentists and other providers to pick treatments for their child that they have all agreed upon.
4. If the Member has a disagreement with DentaQuest, they must try first to resolve it using DentaQuest's complaint process.
5. The Member must learn about what DentaQuest does and does not cover. The Member must read the Member Handbook to understand how the rules work.
6. If the Member makes an appointment for their child, they must try to get to the dentist's office on time. If they cannot keep the appointment, they must be sure to call and cancel it.
7. The Member must report misuse of CHIP by dental and health care providers, other CHIP Members, DentaQuest, or other CHIP plans.

If you think that you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. The Member can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Fraud and Abuse 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 providers, 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 and 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form.
- You can also report fraud directly to DentaQuest:

DentaQuest-TX HHSC Dental Services
Attention: Utilization Review Department
P.O. Box 2906
Milwaukee, WI 53201-2906
Toll-free at 1-800-237-9139

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.

J. Medicaid and CHIP Encounter Data, Billing, and Claims Administration

Where to Send Claims/Encounter Data

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

- Electronic claims via DentaQuest's website (www.dentaquest.com).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims (ADA Claim Form 2018, 2019, or newer)

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 TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration 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 not received instruction on how to complete Provider Self Registration, you can access the guide at http://www.dentaquest.com/getattachment/State-Plans/Regions/texas/Dentists-Page/New-Provider-Registration-Tip-Sheet.pdf. If you need further assistance, please contact DentaQuest's Customer Service Department at 1-800-896-2374.

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please contact the Systems Operations Department at 800-417-7140 or via e-mail at EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

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 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 1-800-896-2374. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

Electronic Claim Submission via Clearinghouse

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

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

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.

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/#/ 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.

Paper Claim Submission

- Claims must be submitted on 2018, 2019, or later ADA approved claim forms.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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 two (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- TX HHSC Dental Program
P.O. Box 2906
Milwaukee, WI 53201-2906

For questions, providers may contact DentaQuest Provider Services at 1-800-896-2374.

Coordination of Benefits (COB)

The TX HHSC Medicaid/CHIP Dental Program/DentaQuest is the payer of last resort. Providers should ask Members if they have other dental insurance coverage at the time of their appointment. When TX HHSC Medicaid/CHIP Dental Program/DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary

Current Dental Terminology © American Dental Association. All Rights Reserved.

carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds the HHSC Dental Services Program's fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

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 1-800-896-2374 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.

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.

Form to Use

Claims must be submitted on a 2018, 2019, or later approved ADA claim form. Please see Appendix B Forms to Use for an ADA claim form.

CHIP Cost Sharing Schedule

CHIP Members are subject to cost sharing and are charged co-pay for each non-preventive office visit (Medicaid Members are not required to pay a co-payment). DentaQuest will deduct the required co-pay from the claim payment. It is the responsibility of the provider to collect the co-pay from the Member at the time of visit.

Current Dental Terminology © American Dental Association. All Rights Reserved.

CHIP Cost Sharing	
	Effective January 1, 2014**
Enrollment Fees (for 12 month enrollment	
	Charge
At of Below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	Charge
Office Visit (non-preventive)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission)	$35
Cost-sharing Cap	5% (of family's
Above 151% up to and including 186% FPL	Charge
Office Visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$75
Cost-sharing Cap	5% (of family's
Above 186% up to and including 201% FPL	Charge
Office Visit (non-preventative)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$125
Cost-sharing Cap	5% (of family's

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
** Per 12-month term of coverage.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

No Co-Payments for Medicaid Members

Medicaid Members are not to be charged a co-payment for dental services.

Billing Members

Member Acknowledgement Statement

Participating Providers shall hold Members, DentaQuest, and HHSC harmless for the payment of non-Covered Services except as provided in this paragraph. A provider may charge an eligible Medicaid/CHIP HHSC Dental Program Member for dental services which are non-covered services. These services must be identifiable by specific CDT code. A provider may bill a Member for non-Covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- The services to be provided.
- DentaQuest and HHSC will not pay for or be liable for said services.
- Member will be financially liable for such services.

Please note that prior authorization may be requested for non-covered services for eligible Medicaid Members under age 21. Documentation of medical necessity must be submitted with this request. This documentation may include radiographs, treatment plan, and/or a narrative from the provider.

Private Pay Form Agreement

Please use the Non-Covered Service Disclosure form located in the Appendix.

Time Limit for Submission of Claims/Claims Appeals

DentaQuest must receive your claim requesting payment of services within ninety-five (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 TX HHSC Dental Program/DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

For appealed claims, Providers must submit all appeals of denied claims and requests for adjustments on paid claims within **one hundred and twenty (120) days** from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Claims Payment

- Clean Claim payment must be made by DentaQuest within thirty (30) days.
- DentaQuest must receive your claim requesting payment of services within ninety-five (95) days from the date of service.
- Claims must be submitted on a 2018, 2019, or later approved ADA claim form.
- For Claims Questions, please send an email to: txclaims@dentaquest.com

  Or call our Provider Hotline at:
  1-800-896-2374

  Or Fax Claims/payment issues to:
  262-241-7379

- For Claims Appeals, please send to:

  DentaQuest TX HHSC Dental Services
  Stratum Executive Center
  11044 Research Blvd
  Building D, Suite D-400
  Austin, TX 78759

- For Peer to Peer Review, please call our Provider Services line during regular business hours:

  1-800-896-2374

K. Medicaid and CHIP Special Access Requirements

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:

- Member Services and our Member Advocate department are staffed with Spanish and English bilingual specialists.
- A Member may request a telephonic interpreter or a face-to-face interpreter through our Member Services Department

TDD access for Members who are hearing impaired: 7-1-1

DentaQuest Member Services and health education materials are available in English and Spanish.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Dental Contractor/Provider Coordination

DentaQuest is committed to ongoing coordination with Texas Medicaid and CHIP Dental Services providers and Members to ensure high quality dental care. We refer Members to contracted dentists for covered services and provide coordination of non-capitated services.

Coordination of care includes:

- Identifying providers of medically necessary dental services.
- Assisting Members in accessing medically necessary dental services.

DentaQuest is available for ongoing coordination with providers via our Provider Hotline, on-going provider training, Provider Relations Representatives, and Case Management staff. Also, our Member Advocates are available to coordinate care with providers to ensure Members with special health care needs receive services.

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 Members at two public hospitals found that 35 percent of the English-speaking and 62 percent of the Spanish-speaking Members 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.

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 Members and in the long run the health and wellness of the Members 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:

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 Members 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 Members.
- Understanding of the cultural beliefs of health and help seeking patterns of minority Members.
- Understanding of the health service resources for minority Members.
- Understanding of the public health policies and its impact on minority Members and communities.

Skills

- Ability to interview and assess minority Members 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 Members 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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.

Specialty Health Care Needs

Special Health Care Needs are defined as any medically compromising condition that may affect the provision of dental treatment. DentaQuest's Member Advocates serve as a liaison between Members with special health care needs, their dental providers, and when needed, their medical providers. A DentaQuest contracted provider may contact our Member or Provider Hotline to facilitate services for Texas Medicaid and CHIP Members whose medical conditions classify them as special needs Members. The Member Advocates will ensure that Members with special health care needs have direct access to specialist providers as appropriate to their condition and identified health needs (e.g., a standing referral to a specialty physician).

L. DentaQuest Information

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. Contracting dentists may not impose any limitations on the acceptance or treatment of Texas Medicaid or CHIP Dental Services Members not imposed on other Members. The dentist is required to maintain the dentist/patient relationship with the Texas Medicaid or CHIP Dental Services Member and shall be solely responsible to the Member for dental advice and treatment.

DentaQuest communicated information on October 29, 2018 regarding the standard of care review that will be effective February 1, 2019 for restorations repeated within 36 months. As a follow-up, DentaQuest would like to provide the process steps that providers must take to ensure services are reviewed and considered for reimbursement.

Any restoration that meets the criteria below will be reviewed for standard of care to ensure the services are medically necessary for the member. Please follow one of the processes outlined below for consideration of the service:

Identical Restoration: (same tooth, exact same service), same provider or location (Prior Authorization or Pre-Payment Review)

Current Dental Terminology © American Dental Association. All Rights Reserved.

Codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

Prior Authorization

1. Prior Authorization must be submitted for review prior to service being performed
2. Documentation must clearly support medical necessity (x-rays, narrative, photos…etc.)
3. Any claim submitted that does not have an approved Prior Authorization and does not have Exception written in Box 35 (comments) will be denied

Pre-Payment Review

1. Services may be submitted using the pre-payment review process. This means that all documentation must be submitted with the claim
2. Documentation must clearly support medical necessity (x-rays, narrative, photos…etc.)
3. The word "Exception" must be placed in Box 35 (comments) section of the claim
4. Any claim submitted that does not meet the pre-payment review requirements listed in #2 and #3 will not be reviewed for consideration.

Similar Restoration: (same tooth, at least one surface repeated), same provider or location (Prior Authorization or Pre-Payment Review)

Codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

Prior Authorization

1. Prior Authorization may be submitted for review prior to service being performed
2. Documentation must clearly support medical necessity (x-rays, narrative, photos…etc.)
3. If Prior Authorization is approved, claim may be submitted for reimbursement consideration

Pre-Payment Review

1. Services may be submitted using the pre-payment review process. This means that all documentation must be submitted with the claim
2. Documentation must clearly support medical necessity (x-rays, narrative, photos…etc.)
3. The word "Exception" must be placed in Box 35 (comments) section of the claim
4. Any claim submitted that does not meet the pre-payment review requirements listed in #2 and #3 will not be reviewed for consideration

Numerous studies on restorations, including appropriateness, materials and longevity have been researched. For your review, the following may be of interest.

https://jada.ada.org/article/S0002-8177(14)62395-3/abstract

Current Dental Terminology © American Dental Association. All Rights Reserved.

http://www.aapd.org/media/Policies_Guidelines/G_Restorative.pdf

If you have any questions or need assistance, please contact your Regional Provider Relations Representative**.**

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.
- Otherwise conduct themselves in a businesslike and professional manner.

Credentialing (Policies 300 Series)

DentaQuest, in conjunction with the Program, 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)

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 1-800-896-2374 or via e-mail at denelig.benefits@dentaquest.com

Broken Appointments – Best Practices

Broken appointments are a concern for the Texas HHSC Medicaid and CHIP Dental Program 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 HHSC Medicaid and CHIP Dental 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 Members they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- Continuing care appointments made for three (3) to six (6) months ahead should be reserved for Members of record with no history of broken appointments.
- Members with a history of broken appointments or Members that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency Members will not keep future appointments if scheduled on the day of emergency treatment. These Members 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 Members 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 Members that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many Members cite daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of

Current Dental Terminology © American Dental Association. All Rights Reserved.

the week or occasional weekend hours can alleviate this barrier to accessing dental care.

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.

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-22)
- 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 HHSC Dental Program

      P.O. 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 Provider Web Portal 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.

Advance Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult members who are 18 years of age and older about their rights under state and federal law, in advance of their receiving care (*Social Security Act* §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the member's right to refuse, withhold, or withdraw medical treatment advance directives.

These policies and procedures must comply with provisions contained in 42 *Code of Federal Regulations* (CFR) §§434.28 and 489, SubPart I, relating to the following state laws and rules:

- A member's right to self-determination in making health-care decisions.
- The *Advance Directives Act*, Chapter 166, Texas Health and Safety Code, which includes:
    - A member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
    - A member's right to make written and non-written Out-of-Hospital Do-Not-Resuscitate Orders.
    - A member's right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the member's behalf if the member becomes incompetent.

The *Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code,* which includes a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a member's advance directive. A statement of limitation on implementing a member's advance directive should include at least the following information:

Current Dental Terminology © American Dental Association. All Rights Reserved.

- A clarification of the provider's conscience objections.
- Identification of the state legal authority permitting a provider's conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.
- A provider cannot require a member to execute or issue an advance directive as a condition for receiving health-care services.
- A provider cannot discriminate against a member based on whether or not the member has executed or issued an advance directive.
- A provider's policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

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.

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 of 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

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.

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 is 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

Current Dental Terminology © American Dental Association. All Rights Reserved.

quadrant will be covered subject to consultant review.

- An unerupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations and substantial (> 50%) root formation.

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.
- Narrative demonstrating medical necessity is required if radiographs are not available.

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 periapical radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved.
- 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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.

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.
- 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).

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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.

Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

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 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 if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other 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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

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

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

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

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

Authorization and treatment using stainless steel 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 with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.

Criteria for Authorization of Operating Room (OR) Cases
Documentation needed for authorization of procedure:

- Treatment Plan (prior-authorized, if necessary).

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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.

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Authorizations for removable prosthesis will not meet criteria:

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

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:

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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.

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.

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:

Current Dental Terminology © American Dental Association. All Rights Reserved.

- 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 noncompliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 6 years old and younger with extensive procedures to be accomplished.

For Members Ages Six and Under

Prior Authorization Criteria

Requests for prior authorization must include, but are not limited to, the following member-specific documents and information:

- A completed Criteria for Dental Therapy Under General Anesthesia form
- A completed Prior Authorization Claim Form. This must include CDT code (s) for all procedures to be performed and D9222/D9223 or D9500 (a DentaQuest specific code that indicates Medical Anesthesia Services) based on place of service and anesthesiologist type
- Location where the procedure(s) will be performed (office or outpatient)
- Tentative date of service if outpatient request or in office using a medical anesthesiologist
- Narrative unique to the member, detailing reasons for the proposed level of anesthesia (indicate procedure code D9222/D9223 or D9500). The narrative must include history of prior treatment, failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs
- When appropriate radiographs or photographs cannot be ta ken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For these special cases that receive authorization, diagnostic quality labeled radiographs or photographs will be required for payment and will be reviewed by the DentaQuest Dental Director.

Current Dental Terminology © American Dental Association. All Rights Reserved.

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or re imbursement for members who are six years of age and younger.

Note: In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the DentaQuest Dental Director.

A copy of the Criteria for Dental Therapy under General Anesthesia form must be maintained in the member's dental record. The member's dent al record must be available for review by representatives of the Health and Human Services Commission (HHSC) or its designee.

The following outlines the process based on place of service (in office / outpatient) and anesthesiologist type (dental / medical).

Dental Therapy under General Anesthesia - In Office

1. Treating Dentist using Dental Anesthesiologist

- Is responsible for obtaining prior authorization from DentaQuest and is responsible for providing the anesthesia prior authorization information to the dental anesthesiologist
- Submits one D9222, appropriate units of D9223, and CDT code(s) that will be performed under general anesthesia for prior authorization DentaQuest will determine medical necessity of the general anesthesia based on the submitted treatment plan and required documentation
- DentaQuest will notify the treating dentist of the determination via a Provider Determination Letter (PDL). For services that are approved, the treating dentist would then provide a copy of the PDL to the dental anesthesiologist. Code D9223 will indicate the DentaQuest determination and will be either approved or denied. While we are reviewing the necessity of the general anesthesia on the overall treatment plan, certain services on the PDL will indicate Service Not Reviewed if they do not typically require authorization under DentaQuest policy. Failure to submit per Prior Authorization Criteria as outlined above will result in a denial. See example below, indicating the anesthesia service (D92 22 /D9223) has been approved.

D9222	deep sedation/general anesthesia – first 15 minutes	1	Approved	Advisory
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	1	Approved	Advisory

Dental Anesthesiologist

- Upon completion of the approved services, the dental anesthesiologist will submit claims to DentaQuest
- The DentaQuest approved authorization number from treating dentist must be in "Box 35" of

Current Dental Terminology © American Dental Association. All Rights Reserved.

the claims form or in the notes section of the portal

- Must submit one D9222 and appropriate units of D9223 with supporting documentation
- Must have a current level 4 permit

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to DentaQuest

2. Treating Dentist using Medical Anesthesiologist

- Is responsible for obtaining prior authorization from DentaQuest and is responsible for providing the anesthesia prior authorization information to the medical anesthesiologist
- Submits D9500 and CDT code(s) that will be performed under general anesthesia for prior authorization
- DentaQuest will determine medical necessity of the general anesthesia based on the submitted treatment plan and required documentation.
- DentaQuest will notify the treating dentist of the determination via a Provider Determination Letter (PDL). For anesthesia that is approved, the treating dentist would then provide a copy of the PDL to the medical anesthesiologist. Code D9500 will indicate the DentaQuest determination and will be either approved or denied. While we are re viewing the necessity of the general anesthesia on the overall treatment plan, certain services on the PDL will indicate Service Not Reviewed if they do not typically require authorization under DentaQuest policy. Failure to submit per Prior Authorization Criteria as outlined above will result in a denial. See example bel ow, indicating the medical anesthesia service (D9500) has been approved.

D2930	prefabricated stainless steel crown - primary tooth	Tooth T	1	Service Not Reviewed	Advisory
D9500	medical anesthesia services		1	Approved	Advisory

Medical Anesthesiologist

- Is responsible for submitting a separate prior authorization request to the member's MCO along with the approved DentaQuest PDL
- The MCO reviews submitted documentation from DentaQuest to determine whether medical anesthesia is approved or denied
- Upon completion of the approved services, the medical anesthesiologist will submit claim s to the member's MCO using the appropriate CPT code(s)

- Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to DentaQuest

Current Dental Terminology © American Dental Association. All Rights Reserved.

Dental Therapy under General Anesthesia – Outpatient

Treating Dentist

- Is responsible for obtaining prior authorization from DentaQuest and is responsible for providing the anesthesia prior authorization information to the medical anesthesiologist and / or facility
- Submits code D9500 and CDT code(s) that will be performed under general anesthesia for prior authorization
- The prior authorization request must indicate tentative procedure date(s) of service and facility name in "Box 35" (remarks) of the ADA claim form
- Place of service must also be indicated in "Box 38" of the ADA claim form.
- DentaQuest will determine medical necessity of the general anesthesia based on the submitted treatment plan and required documentation
- DentaQuest will notify the treating dentist of the determination via a Provider Determination Letter (PDL). For anesthesia that is approved, the treating dentist would then provide a copy of the PDL to the medical anesthesiologist and / or facility. Code D9500 will indicate the DentaQuest determination for Medical Anesthesia Services

D2930	prefabricated stainless steel crown - primary tooth	Tooth T	1	Service Not Reviewed	Advisory
D9500	medical anesthesia services		1	Approved	Advisory

Medical Anesthesiologist and / or Facility

- Is responsible for submitting a separate prior authorization request to the member's MCO along with the approved DentaQuest PDL
- The MCO reviews submitted documentation from DentaQuest to determine whether medical anesthesia and/or facility is approved or denied
- Upon completion of the approved services, the medical anesthesiologist and / or facility will submit claims to the member's MCO using the appropriate CPT code(s)

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to DentaQuest

Please remember that the provider who submits the authorization for the dental therapeutic services must be the provider that performs the services. If the authorized provider does not perform the service, claims will deny. In the event the authorized provider is un able to perform the services, DentaQuest must be notified to update the authorization **prior to the services**

Current Dental Terminology © American Dental Association. All Rights Reserved.

being performed. This is not applicable to the anesthesiologist.

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 significant loss of bone support.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Appendix A
Definitions

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

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

- a Medicaid or CHIP beneficiary, directly or on behalf of TX HHSC, as agreed upon between the State of Texas and or its regulatory agencies and DentaQuest (a "Medicaid Contract");

B. "Covered Services" is a dental service or supply , including those services covered through the Texas Health Steps Program that satisfies all of the following criteria:

- Is medically necessary;
- Is covered under the Texas HHSC Medicaid Dental Program;
- Is provided to an enrolled Member by a Participating Provider; and
- Is authorized by DentaQuest in accordance with the program guidelines.

C. "HHSC" means the Texas Health and Human Services Commission

D. "DentaQuest" shall refer to DentaQuest USA Insurance Company, Inc.

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

F. "Medically Necessary" is a service or benefit that is:

- Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- Consistent with currently accepted standards of good medical practice;
- The most cost effective service that can be provided without sacrificing effectiveness or access to care; and
- Not primarily for the convenience of the consumer, family or provider.

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

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

J. “Provider Dentist” is a Doctor of Dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

Current Dental Terminology © American Dental Association. All Rights Reserved.

Appendix B
Forms to Use

Current Dental Terminology © American Dental Association. All Rights Reserved.

DentaQuest USA Insurance Company

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

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 ☐U
8. Policyholder/Subscriber ID (Assigned by Plan)
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 (Assigned by Plan 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 ☐U
15. Policyholder/Subscriber ID (Assigned by Plan)
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 ☐U
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-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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

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

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X ____ Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number
58. Additional Provider ID

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at adacatalog.org

Current Dental Terminology © American Dental Association. All Rights Reserved.

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 posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

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 instructions posted on the ADA's web site (ADA.org).

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.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

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).

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 (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:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/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:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

DentaQuest USA Insurance Company, Inc October 1, 2020
Current Dental Terminology © American Dental Association. All Rights Reserved.

OrthoCAD Submission Form

Date:_____

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

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

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

DentaQuest USA Insurance Company, Inc October 1, 2020
Current Dental Terminology © American Dental Association. All Rights Reserved.

Continuation of Care Submission Form

Date: _____

Patient Information

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

Provider Information

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

Name of Previous Vendor that issued original approval:_____

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

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

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

Balance Expected for Future Dates of Service: _____

Numbers of Adjustments Remaining: _____

<u>Additional information required:</u>

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

Mail to:
DentaQuest, LLC Attn: Continuation Of Care
P.O. Box 2906
Milwaukee, WI 53201-2906

DentaQuest USA Insurance Company, Inc October 1, 2020
Current Dental Terminology © American Dental Association. All Rights Reserved.

Children's Medicaid Dental Services
Managed Care Orthodontia Review Policy and Procedure- Texas

Subject: Orthodontia Review Policy and Procedure
Effective Date: March 1, 2012
Date Last Revised: December 20, 2011; January 18, 2012; January 30, 2012

Purpose

The Dental Contractors established a managed care policy and process to ensure consistent and equitable determination of orthodontic coverage for the children's Medicaid and CHIP dental services. Comprehensive medically necessary orthodontic services are a covered benefit for Texas Medicaid Members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Orthodontic services are covered for Texas CHIP Members for pre-and postsurgical cases related to cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Definitions

Severe handicapping malocclusion is defined as an occlusion that is severely functionally compromised and is described in detail in Levels I, II, III, and IV.

Orthodontic terminology and extent of orthodontic services are based on the American Dental Association's Current Dental Terminology (CDT) definitions and explanations of the orthodontic codes utilized within this policy. The following definitions of dentition established by the CDT manual are recognized by the Children's Medicaid dental services:

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Policy

Current Dental Terminology © American Dental Association. All Rights Reserved.

The Dental Contractors recognize four orthodontic service levels for severe handicapping malocclusion, and each requires a different amount of time for treatment. These levels require different levels of skill, orthodontic procedures, and time for completion of the treatment plan.

1.1 Level I: Dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework. (Presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth shall constitute the early mixed dentition.)

- Anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession, or severe enamel wear.
- Posterior crossbite with an associated midline deviation and asymmetric closure pattern.
- Dental cross bites, other than the above described shall not be eligible for treatment in Level I.

1.2 Level I orthodontic services must be completed within 12 months unless an exception is granted by DentaQuest upon approval of a prior authorization request submitted by the provider.

1.3 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

1.4 Providers may submit the following procedure codes for Level I review:

Procedure Code	Description
D8010	Limited orthodontic treatment of the primary dentition.
D8020	Limited orthodontic treatment of the transitional dentition.
D8210	Removable appliance therapy
D8220	Fixed appliance therapy

1.5 Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

2.1 Level II:

2.2 Qualification for treatment at Level II requires submission of documentation to support the classification of handicapping malocclusion. FOUR of the following conditions must be clearly apparent in the supporting documentation:

Current Dental Terminology © American Dental Association. All Rights Reserved.

A. Full cusp Class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar.

B. Full cusp Class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of mandibular molar distal buccal cusp.

C. Overbite measurement shall be in excess of 5 mm.

D. Overjet measurement shall be in excess of 8 mm.

E. More than four congenitally absent teeth, one or more of which shall include an anterior tooth/ or teeth.

F. Anterior crowding shall be in excess of 6 mm. in the mandibular arch.

G. Anterior cross bite of more than two of the four maxillary incisors.

H. Generalized spacing in both arches of greater than 6 mm. in each arch.

I. Recognition of early impacted maxillary canine or canines. Radiographs shall support the diagnosis demonstrating a severe mesial angulation of the erupting canine and the crown of the canine superimposed and crossing the image of the maxillary lateral incisor.

2.3 Level II orthodontic services must be completed within 24 months unless an exception is granted.

2.4 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

2.5 Providers must use the appropriate procedure code that is applicable for banding:

Procedure Code	Description
D8050	Interceptive orthodontic treatment of the primary dentition.
D8060	Interceptive orthodontic treatment of the transitional dentition.
D8070	Comprehensive orthodontic treatment of the transitional dentition. (1 of D8070, D8080 or D8090 per lifetime)
D8080	Comprehensive orthodontic treatment of the adolescent dentition. (1 of D8070, D8080 or D8090 per lifetime)

Current Dental Terminology © American Dental Association. All Rights Reserved.

Procedure Code	Description
D8090	Comprehensive orthodontic treatment of the adult dentition. (1 of D8070, D8080 or D8090 per lifetime)

2.6 Interceptive orthodontic treatment is not covered in conjunction with comprehensive orthodontic treatment. In addition, interceptive orthodontic treatment is not allowed when comprehensive orthodontic treatment is indicated unless there are extenuating circumstances.

2.7 Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

3.1 Additional Services: There may be extenuating circumstances that warrant additional treatment, including but not limited to craniofacial anomalies and cleft palate. In the event that the Member requires additional treatment, the Provider may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity. Level III and Level IV described below are the clinical criteria that must be met in order to qualify for additional services.

3.2 To submit for additional services, the provider must complete the following:

A. Submit a prior authorization on a 2018, 2019, or greater ADA claim form with the appropriate code(s) being requested

B. If the provider is requesting additional monthly adjustments, the code D8670 must be utilized

C. Recent radiographs (x-rays) showing the progress made to current

D. Photographs

E. Treatment plan

4.1 Level III: Dedicated to resolution of handicapping malocclusion in the adolescent or adult dentition.

4.2 Qualification for treatment at Level III requires submission of documentation to support the classification of handicapping malocclusion. FOUR of the following conditions must be clearly apparent in the supporting documentation.

A. Full cusp Class II molar malocclusion as described in Level II.

B. Full cusp Class III molar malocclusion as described in Level II.

C. Anterior tooth impaction; unerupted with radiographic evidence to support a

Current Dental Terminology © American Dental Association. All Rights Reserved.

diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth which may be malposed but has erupted into the oral cavity and is not a qualifying element.

D. Anterior crowding shall be in excess of 6mm in the mandibular arch.

E. Anterior open bite shall demonstrate that all maxillary and mandibular incisors have no occlual contact and are separated by a measurement in excess of 6 mm.

F. Posterior open bite shall demonstrate a vertical separation by a measurement in excess of 5 mm. of several posterior teeth and not be confused with the delayed natural eruption of a few teeth.

G. Posterior cross bite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch shall qualify.

H. Anterior cross bite shall include more than two incisors in cross bite and demonstrate gingival inflammation, gingival recession, or severe enamel wear.

I. Over bite shall be in excess of 5 mm.

J. Overjet shall be in excess of 8 mm.

4.3 Level III orthodontic services must be completed within 36 months unless an exception is granted.

4.4 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

5.1 Level IV: Dedicated to resolution of handicapping malocclusion in the adult dentition; complete eruption of the permanent dentition.

5.2 Qualification for treatment at level IV requires submission of documentation to support the classification of handicapping malocclusion. Documentation shall be submitted by an Oral Surgeon justifying the medical necessity of a surgical approach to treatment.

A. Non-functional Class II malocclusion.

B. Non-functional Class III malocclusion

5.3 Models, panorex, Cephalogram, and photos shall be submitted with the above requested documentation for review. The correction of the malocclusion shall be beyond that of orthodontics alone and shall require pre-orthodontic and post-orthodontic procedures in conjunction with orthognathic surgery. The patient's medical needs shall be based on function and not esthetics.

Current Dental Terminology © American Dental Association. All Rights Reserved.

5.4 Level IV orthodontic services must be completed within 48 months unless an exception is granted.

5.5 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

6.1 Other Orthodontic Services:

6.2 The following procedure codes are used to bill for other orthodontic services:

Procedure Code	Description
D8670	Periodic orthodontic treatment visit - the number of monthly adjustments will vary based on which level was approved.
D8680	Debanding- Orthodontic retention (removal of appliances, construction and placement of retainers).
D8691	Repair of orthodontic appliance- 1 per arch per lifetime.
D8692	Replacement of lost or broken retainer- 1 per arch per lifetime. Documentation of medical necessity needed.
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers- Documentation of medical necessity needed.

7.1 Provider Requirements:

7.2 All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of Dentist.

7.3 Dentists (DDS, DMD) who want to provide any of the four levels of orthodontic services addressed in this policy must be enrolled as a dentist or orthodontist in Texas Health Steps and must have the qualifications listed below for the relevant level of service:

Current Dental Terminology © American Dental Association. All Rights Reserved.

Level of Orthodontic Service	Qualifications
Level I or II	Completion of pediatric dental residency; or a minimum of 200 hours of continuing dental education in orthodontics.
Level I, II, III, or IV	Dentists who are orthodontic board certified or orthodontic board eligible.

7.4 Provider Type 90 – Orthodontist: Board eligible or board certified by an ADA recognized orthodontic specialty board. This provider type is eligible to provide Level I-IV.

7.5 Provider Type 48 – Texas Health Steps – Dental: In order to perform and be reimbursed for Level I and II, provider must attest to either:

A. Completion of pediatric specialty residency.

B. Minimum of 200 hours of continuing dental education in orthodontics within the last ten years.

8.1 Orthodontic Prior Authorization Requirements

8.2 The following documentation must be submitted with the request for prior authorization:

A. ADA 2018, 2019, or newer claim form with service codes noted

B. Duplicate diagnostic models or a complete set of diagnostic photographs

C. Radiographs (x-rays)

D. Cephalometric x-ray with tracings

E. Photographs (if plaster models are submitted)

F. Treatment plan

G. **For CHIP Members Only** – a copy of the medical prior authorization approval letter for surgery

9.1 Completion of Comprehensive Orthodontic Services

9.2 Prior authorization is required for completion of services (last payment) and must be reviewed for proof of completion of case.

9.3 The following documentation must be submitted with the request for prior authorization:

A. Post treatment panorex film

B. Photographs

C. A signed statement from the treating Provider indicating that treatment is

Current Dental Terminology © American Dental Association. All Rights Reserved.

complete

9.4 Providers must use the following procedure code for debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s))

10.1 Transfer of Comprehensive Orthodontic Services

10.2 Prior authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the treatment initiated by the original provider.

10.3 The new provider must obtain his/her own records. The following supporting documentation of medical necessity must be submitted with the request for transfer of services:

A. All of the documentation that is required for the original request,

B. The reason the Member left the previous provider,

C. Narrative noting the treatment status.

11.1 Continuation of Orthodontic Case Initiated through a Private Arrangement

11.2 Continuation of a case for a Member that began treatment through a private arrangement will be considered for prior authorization if the Member began treatment prior to becoming Medicaid eligible.

11.3 Continuation of a case for a Member that began treatment through a private arrangement will not be considered for prior authorization if the Member began treatment while Medicaid eligible and will be denied.

11.4 The following information is required for consideration of payment for continuation of care cases:

A. A completed Orthodontic Continuation of Care Form

B. A completed 2018, 2019, or greater ADA claim form listing the services to be rendered

C. A copy of the Member's prior approval including the total approved case fee and payment structure

D. Detailed payment history

11.5 If the Member is private pay, fee for service or transferring from a commercial insurance and now is Medicaid or CHIP eligible; the following information is required:

A. A completed Orthodontic Continuation of Care Form

B. A completed 2018, 2019, or greater ADA claim form listing the services to be rendered

Current Dental Terminology © American Dental Association. All Rights Reserved.

C. A copy of the Member's prior approval including the total approved case fee and payment structure

D. Detailed payment history

E. A copy of the original study models prior to the patient being banded

F. Panorex film

12.1 Orthodontic Services authorized by TMHP prior to March 1, 2012

12.2 The Dental Contractor has the option to re-review any and/or all orthodontic cases authorized by TMHP prior to March 1, 2012 for medical necessity.

12.3 The following information is required for review and consideration of payment for continuation of care:

A. A completed Orthodontic Continuation of Care Form

B. A completed 2018, 2019, or greater ADA claim form listing the services to be rendered

C. A copy of the Member's prior approval including the total approved case fee and payment structure

D. Detailed payment history

E. A copy of the original study models prior to the patient being banded (only if requested)

F. Panorex film (only if requested)

12.4 The clinical criteria used in making the qualifying decision will be the criteria stated in this document (Level I, II, III and IV).

12.5 Should the request for continuation of payment be denied due to lack of medical necessity under the new clinical criteria; the Dental Contractor will authorize a treatment plan to deband the Member.

13.1 Premature Termination of Comprehensive Orthodontic Services

13.2 Premature termination of comprehensive orthodontic treatment by the originally treating provider is included in the comprehensive services.

13.3 Premature termination of orthodontic services includes all of the following:

A. Removal of brackets and arch wires

B. Other special orthodontic appliances

C. Fabrication of special orthodontic appliances

D. Delivery of orthodontic retainers

13.4 Premature removal of an orthodontic appliance must be prior authorized. A release form must be signed by the parent or legal guardian, or by the Member if he/she is 18 years of age or older or an emancipated minor. A copy of the signed release form and a completed prior authorization request form must be

Current Dental Terminology © American Dental Association. All Rights Reserved.

submitted, and one of the following must be documented on the prior authorization request:

A. The Member is uncooperative or is non-compliant

B. The Member requested the removal of the orthodontic appliance(s)

C. The Member has requested the removal due to extenuating circumstances to include, but not limited to:

1. Incarceration
2. Mental health complications with a recommendation from the treating physician
3. Foster Care placement
4. Child of a Migrant Farm Worker, with the intent to complete treatment at a later date if Medicaid eligibility for orthodontic services continues

NOTE: A Member for whom removal of an appliance has been authorized due to the above, will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while Medicaid eligible. Should the Member choose to have the appliances removed for reasons other than those listed under "C", the Member ***may not*** *be eligible for any additional Medicaid orthodontic services.*

13.5 The requesting provider is responsible for removal of the orthodontic appliances, final records and x-rays at the time of termination.

13.6 Providers must use the following procedure code for premature debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s))

14.1 Reimbursement:

14.2 An initial payment is payable when bands are placed. Providers must bill with the appropriate prior authorized procedure code.

14.3 Providers must bill the appropriate monthly adjustment code (D8670). The total number of monthly adjustments allowed will vary by level.

14.4 The last payment is payable when the treatment is complete. Providers must bill with the appropriate prior authorized procedure code (D8680).

15.1 General Information:

15.2 Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity. For example, debanding in regular treatment would limit retainers and appliance removal to a single episode however in the case of cleft palate, craniofacial and head trauma with dental consequences; the case may

Current Dental Terminology © American Dental Association. All Rights Reserved.

involve multiple courses of treatment and would gain additional consideration based on the circumstances.

15.3 Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

15.4 Members enrolled in the Dental Contractor's plan for at least one month and are receiving orthodontic treatment and either ages out or loses eligibility; the Dental Contractor is responsible for completion of payment for the course of treatment. The only exception is if the Member is disenrolled with cause, but is still Medicaid eligible.

15.5 There will be no payment for denied cases.

15.6 Payment for banding includes the initial work up.

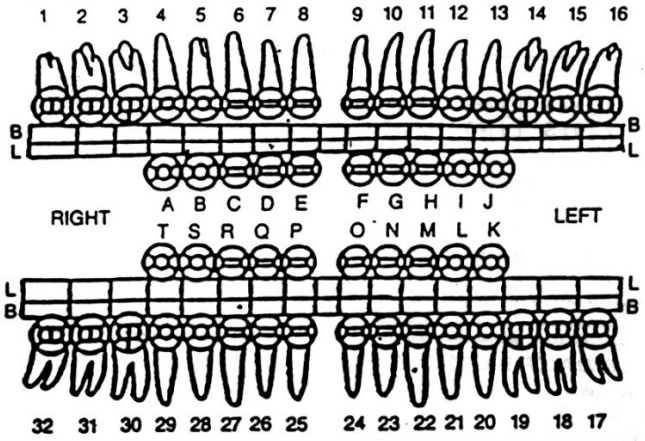
15.7 Study models submitted with the request will not be returned to the provider unless a self-addressed postage paid box is included.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved.

MEDICAL AND DENTAL HISTORY

Patient Name:_____Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having pain or discomfort at this time? Yes/No ___ If yes,

what type and where? _____

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

Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? Yes/No ___ No Are you

now taking any medication, drugs, or pills? Yes/No ___

If yes, please list medications: _____

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

If yes, please list: _____

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

Do your ankles swell during the day? Yes/No ___

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

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

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

Are you on a special diet? Yes/No ___

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

No If yes, please list: _____

Current Dental Terminology © American Dental Association. All Rights Reserved.

DentaQuest USA Insurance Company

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

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

For Women Only:

Are you pregnant? Yes/No___

If yes, what month? _____

Are you nursing? Yes/No___

Are you taking birth control pills? Yes/No___

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

Patient Signature:_____Date: _____

Dentist's Signature:_____Date: _____

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

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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.)

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

APPENDIX C

Covered Benefits (See Exhibits)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Medicaid Members under the age of 21 and CHIP Members under the age 19. **Providers with benefit questions should contact DentaQuest's Customer Service department directly at:**

800.896.2374, 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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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

Current Dental Terminology © American Dental Association. All Rights Reserved.

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:

"Review 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:"

"Review 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

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)

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 good diagnostic quality, include member's full name, date films taken, and identify the patients left and right side. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment 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.

Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit.

When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.

Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM

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

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	Limited to one every six months by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	0-20		No	Limited to one service per day by the same provider OR location or two services per day per patient by different providers. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with routine dental services. Document of Medical Necessity must be indicated on the claim.	narrative of medical necessity
D0145	first dental home oral evaluation	6-35 months		No	Providers must be certified by Texas Health Steps staff to perform this procedure as a First Dental Home (FDH) Provider. Members are limited to one D0145 per day with a maximum of 10 services allowed per member's lifetime with at least 60 days between dates of service per provider. Cannot be billed within a 6-month period of a (D0120 or D0150). Codes D1330, D1206, D1120, and D1208 will be denied when billed on the same date of service as a D0145. D0145 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	Limited to one service every three years by the same provider or location. Denied when submitted for the same DOS as D0145 by any provider. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0160	detailed and extensive oral eval-problem focused, by report	1 - 20		No	Limited to one service per day by the same provider OR location. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0170	re-evaluation, limited problem focused	0-20		No	Limited to one service per day by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity
D0180	comprehensive periodontal evaluation - new or established patient	13 - 20		No	Limited to one service per day by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity
D0210	intraoral - complete series of radiographic images	2-5		Yes	Limited to one service of D0210, D0277, D0330 every three years by the same provider OR location. Narrative of medical necessity and x-ray.	narr. of med. necessity, pre-op x-ray(s)
D0210	intraoral - complete series of radiographic images	6 - 20		No	Limited to one service of D0210, D0277, D0330 every three years by the same provider OR location.	
D0220	intraoral - periapical first radiographic image	1 - 20		No	Limited to one service per day by the same provider OR location.	
D0230	intraoral - periapical each additional radiographic image	1 - 20		No		
D0240	intraoral - occlusal radiographic image	0-20		No	Limited to two services per day by the same provider OR location.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	1 - 20		No	Limited to one service per day by the same provider OR location.	
D0270	bitewing - single radiographic image	1		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. Narrative of medical necessity and x-ray showing fully erupted primary first molar.	narr. of med. necessity, pre-op x-ray(s)
D0270	bitewing - single radiographic image	2-20		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location.	
D0272	bitewings - two radiographic images	1		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. Narrative of medical necessity and x-ray showing fully erupted primary first molar.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	2-20		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0273	bitewings - three radiographic images	1-9		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient. Narrative of medical necessity and x-rays showing fully erupted left and right second permanent molars.	narr. of med. necessity, pre-op x-ray(s)
D0273	bitewings - three radiographic images	10 - 20		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0274	bitewings - four radiographic images	1-9		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient. Narrative of medical necessity and x-rays showing fully erupted left and right second permanent molars.	narr. of med. necessity, pre-op x-ray(s)
D0274	bitewings - four radiographic images	10 - 20		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0277	vertical bitewings - 7 to 8 films	2 - 20		No	Limited to one service per day by the same provider OR location. Not to be submitted within 36 months of D0210, D0277 or D0330. One service of D0210, D0277 per day per patient.	
D0310	sialography	1 - 20		No		
D0320	temporomandibular joint arthrogram, including injection	1 - 20		No		
D0321	other temporomandibular joint films, by report	1 - 20		No		
D0322	tomographic survey	1 - 20		No		
D0330	panoramic radiographic image	3-5		Yes	Limited to one service of D0210, D0277, D0330 every three years by the same provider OR location. One	narr. of med. necessity, pre-op x-

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
					service of D0210, D0277, D0330 per day per provider. Narrative of medical necessity and x-ray.	ray(s)
D0330	panoramic radiographic image	6 - 20		No	Limited to one service of D0210, D0277, D0330 every three years by the same provider OR location. One service of D0210, D0277, D0330 per day per provider.	
D0340	cephalometric radiographic image	1 - 20		No	Limited to one service per day by the same provider OR location. Not billable with orthodontic work up.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	Limited to one service per day by the same provider OR location. Not billable with orthodontic work up.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-20		Yes	Limited to a combined maximum of three services per year, per patient.	narrative of medical necessity
D0415	bacteriologic studies	1 - 20		No		
D0460	pulp vitality tests	1 - 20		No	Limited to one service per day by the same provider OR location. Not allowed on primary teeth. Not billable with endodontic procedures.	
D0470	diagnostic casts	1 - 20		No	Not billable with crowns, prosthodontics (fixed or removable) orthodontics, or diagnostic work up.	
D0502	other oral pathology procedures, by report	1 - 20		No		
D0601	Caries risk assessment and documentation, with a finding of low risk	0-20		No	Codes D0120, D0145, and 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	0-20		No	Codes D0120, D0145, and 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	0-20		No	Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0999	unspecified diagnostic procedure, by report	1 - 20		Yes		narrative of medical necessity

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 20		No	Limited to one D1110, D1120 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code.	
D1120	prophylaxis - child	0-12		No	Limited to one D1110, D1120 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code.	
D1206	topical application of fluoride varnish	0-20		No	One service of D1206, D1208 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. If submitted on emergency claim, D1206 will be denied. Includes oral health instructions.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One service of D1206, D1208 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure codes D0145, D1330. Includes oral health instructions.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1330	oral hygiene instructions	0-20		No	One service of D1330 per year, per patient, any provider. Denied when billed for the same DOS as oral hygiene instructions (D1330), prophylaxis (D1110 or D1120), or topical fluoride treatments (D1206 or D1208), by any provider.	
D1351	sealant - per tooth	0-20	Teeth 1, 6 - 11, 16, 17, 22 - 27, 32, 51 - 82, C - H, M - R, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. If submitted on emergency claim, D1351 will be denied.	narrative of medical necessity and photos
D1351	sealant - per tooth	0-20	Teeth A, B, I - L, S, T	No	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. If submitted on emergency claim, D1351 will be denied.	
D1351	sealant - per tooth	0-5 15-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. For those members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 6-14 age band. Documentation can also include patient-centric risk factors that may exist If submitted on emergency claim, D1351 will be denied.	narrative of medical necessity
D1351	sealant - per tooth	6-14	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. If submitted on emergency claim, D1351 will be denied.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
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 placement of a sealant in radiating non-carious fissure or pits.	15-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	narrative of medical necessity
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 placement of a sealant in radiating non-carious fissure or pits.	5-14	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	
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 placement of a sealant in radiating non-carious fissure or pits.	5-20	Teeth 1, 16, 17, 32	Yes	Limited to one service of (D1351, D1352) every three years per patient, per tooth by any provider. Denied when billed for the same DOS as any D4000 series periodontal procedure code. For members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 5-14 age band. Documentation can also include patient-centric risk factors that may exist. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	narrative of medical necessity and photos

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1354	interim caries arresting medicament application – per tooth	6 months-6 years	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		D1354 is limited to two applications, per lifetime of tooth, with 30 days minimum separation between application dates. Not allowed on the same day as D1206 or D1208. D1354 is not allowed on teeth which have had D2000 series procedure{s) in prior 12 months. D2000 series procedures are not allowed for 30 days after the application of D1354. D1354 must be deemed medically necessary by Main Dental Home provider.	
D1510	space maintainer-fixed-unilateral – Per Quadrant	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit to one service of (D1510, D1520) every two years, per patient, per quadrant.	
D1516	space maintainer – fixed – bilateral, maxillary	1 - 20	Per Arch (01, UA)	No	Limit to one service of (D1516 or D1526) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1517	space maintainer – fixed – bilateral, mandibular	1 - 20	Per Arch (02, LA)	No	Limit to one service of (D1517 or D1527) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1520	Space maintainer-removable-unilateral	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit to one service of (D1510 or D1520) every two years, per patient, per quadrant.	
D1526	space maintainer – removable – bilateral, maxillary	1 - 20	Per Arch (01, UA)	No	Limit to one service of (D1516 or D1526) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1527	space maintainer – removable – bilateral, mandibular	1 - 20	Per Arch (02, LA)	No	Limit to one service of (D1517 or D1527) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1551	re-cement or re-bond bilateral space maintainer - maxillary	1 - 20	Per Arch (01, UA)	No	Not allowed within 6 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
					Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1552	re-cement or re-bond bilateral space maintainer - mandibular	1 - 20	Per Arch (02, LA)	No	Not allowed within 6 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed within 6 months of initial placement. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1556	removal of fixed unilateral space maintainer - per quadrant	0 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1557	removal of fixed bilateral space maintainer - maxillary	0 - 20	Per Arch (01, UA)	No	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1558	removal of fixed bilateral space maintainer - mandibular	0 - 20	Per Arch (02, LA)	No	Not allowed by same provider OR location that placed appliance. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1575	distal shoe space maintainer – fixed - unilateral	3 - 7	Teeth A, J, K, T	No	Limit to one service of (D1575) per lifetime, per patient, per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
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.
BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE
CEMENTATION OR INSERTION DATE.
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 retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**
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.
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM.
The following codes require prior authorization for all ages: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792, and D2794.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
A replacement of an identical restorative service in less than 36 months by the same provider is not considered the standard of care for quality by DentaQuest. If there are special circumstances requiring this repeat service, please send in a prior authorization request along with a narrative establishing medical necessity.
Direct restoration of a primary tooth through the use of a prefabricated crown is considered to be a once in a lifetime restoration, same tooth, any provider. Exceptions may be considered when pre-treatment x-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown (procedure codes D2930, D2932, D2933, D2934, during pre-payment review.

This document contains proprietary and confidential information and may not be disclosed to others
without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2160	amalgam - three surfaces, primary or permanent	1 - 20	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	1 - 20	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2331	resin-based composite – two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2332	resin-based composite - three surfaces, anterior	1 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 - 20	Teeth C - H, M - R	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934. D2335 and D2390 when provided to primary teeth are limited to once per lifetime, per tooth, any provider.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 - 20	Teeth 6 - 11, 22 - 27	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2390	resin-based composite crown, anterior	0-20	Teeth C - H, M - R	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934. D2335 and D2390 when provided to primary teeth are limited to once per lifetime, per tooth, any provider.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2393	resin-based composite - three surfaces, posterior	1 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2394	resin-based composite - four or more surfaces, posterior	1 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2510	inlay - metallic -1 surface	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2520	inlay-metallic-2 surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2530	inlay-metallic-3+ surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2542	onlay - metallic - two surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2543	onlay-metallic-3 surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2544	onlay-metallic-4+ surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2650	inlay-composite/resin 1surface	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2651	inlay-composite/resin-2 surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2652	inlay-composite/resin-3+ surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2662	onlay-composite/resin-2 surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2663	onlay-composite/resin-3 surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2664	onlay-composite/resin-4+ surfaces	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2710	crown - resin-based composite (indirect)	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2720	crown-resin with high noble metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2721	crown - resin with predominantly base metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2722	crown - resin with noble metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic	13 - 20	Teeth 4-13, 20-29	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2750	crown - porcelain fused to high noble metal	13 - 20	Teeth 4-13, 20-29	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	13 - 20	Teeth 4-13, 20-29	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2752	crown - porcelain fused to noble metal	13 - 20	Teeth 4-13, 20-29	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2780	crown - ¾ cast high noble metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2781	crown - ¾ cast predominantly base metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2782	crown - ¾ cast noble metal	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2783	crown - ¾ porcelain/ceramic	13 - 20	Teeth 6 - 11, 22 - 27	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2790	crown - full cast high noble metal	13 - 20	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2791	crown - full cast predominantly base metal	13 - 20	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2792	crown - full cast noble metal	13 - 20	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2794	crown – titanium and titanium alloys	13 - 20	Teeth 1 - 32	Yes	Limit to one service 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) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	13 - 20	Teeth 1 - 32	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	4 - 20	Teeth 1 - 32	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2920	re-cement or re-bond crown	1 - 20	Teeth 1 - 32, A - T	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Limit to one service per lifetime, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2931	prefabricated stainless steel crown-permanent tooth	1 - 20	Teeth 1 -32	No	D2931 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, or D2932.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2932	prefabricated resin crown	1 - 20	Teeth 1-32, C-H, M-R	No	D2932 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, or D2932.	
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	0-20	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2940	protective restoration	0-20	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	4 - 20	Teeth 1 - 32	No	Limited to one service of D2950 per year, per patient, per tooth. Limit to one service of (D2950, D2952, D2954) per day, per patient, per tooth. Not allowed on primary teeth.	
D2951	pin retention - per tooth, in addition to restoration	4 - 20	Teeth 1 - 32	No	Limited to one service every five years, per patient, per tooth. Not allowed on primary teeth.	
D2952	cast post and core in addition to crown	13 - 20	Teeth 1 - 32	No	Limited to one service every five years, per patient, per tooth. Not allowed on primary teeth. Not payable with D2950.	
D2953	each additional cast post – same tooth	13 - 20	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2952.	
D2954	prefabricated post and core in addition to crown	13 - 20	Teeth 1 - 32	No	Limited to one service of (D2952, D3950) per day, per patient, per tooth. Not allowed on primary teeth.	
D2955	post removal (not in conjunction with endodontic therapy)	4 - 20	Teeth 1 - 32	No	Limited to one service of (D3346, D3347, D3348) per day, per patient, per tooth. Not allowed on primary teeth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2957	each additional prefabricated post - same tooth	13 - 20	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2954.	
D2960	labial veneer (laminate)-chair	13 - 20	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2961	labial veneer (resin laminate) - laboratory	13 - 20	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2962	labial veneer (porc laminate) - laboratory	13 - 20	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2971	additional procedures to construct new crown under partial denture framework	13 - 20	Teeth 1 - 32	Yes	Limited to four services per Lifetime, Per patient, per tooth. Allowed only to the same provider that performed the cementation in conjunction with the crown.	narrative of medical necessity
D2980	crown repair, by report	1 - 20	Teeth 1 - 32	No		
D2999	unspecified restorative procedure, by report	1 - 20	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
"Payment for conventional root canal treatment is limited to treatment of permanent teeth.
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 retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances."

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (excluding final restoration)	1 - 20	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.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	1 - 20	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, D2931, D2932, D2950, D2951, D2952, D2953, D2954, D2955, D2957, D2960, D2961, D2962, D2971, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.same Tooth, same Date of Service: D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3230, D3240, D3310, D3320, or D3330.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 2 - 15, 18 - 31	No	Limited to one service of (D3220, D3230, D3240, D3310, D3320, D3330) per six months, per patient, per tooth.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A - T	No	One service of (D3220, D3230, D3240, D3310, D3320, D3330) per lifetime, per patient, per tooth for primary Teeth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 - 20	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 - 20	Teeth A, B, I - L, S, T	No	Limit to one service per lifetime, per patient, per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6 - 20	Teeth 6 - 11, 22 - 27	No	Limit to one service per lifetime, per patient, per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	6 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Limit to one service per lifetime, per patient, per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	6 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Limit to one service per lifetime, per patient, per tooth.	
D3346	retreatment of previous root canal therapy-anterior	6 - 20	Teeth 6 - 11, 22 - 27	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	6 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	Limit to one service per lifetime, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D3348	retreatment of previous root canal therapy-molar	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	Limit to one service per 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.)	6 - 20	Teeth 1 - 32	No		
D3352	apexification/recalcification – interim medication replacement	6 - 20	Teeth 1 - 32	No		
D3353	apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	6 - 20	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	6 - 20	Teeth 6 - 11, 22 - 27	Yes		narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3421	apicoectomy - premolar (first root)	6 - 20	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)	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3426	apicoectomy (each additional root)	6 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D3430	retrograde filling - per root	6 - 20	Teeth 1 - 32	No		
D3450	root amputation - per root	6 - 20	Teeth 1 - 32	No		
D3460	endodontic end osseous implant	16 - 20	Teeth 1 - 32	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3470	intentional reimplantation	6 - 20	Teeth 1 - 32	No		
D3910	surgical procedure for isolation of tooth with rubber dam	1 - 20	Teeth 1 - 32	No		
D3920	hemi section (including any root removal), not incl root canal therapy	6 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	No		
D3950	canal preparation and fitting of preformed dowel or post	6 - 20	Teeth 1 - 32	No		narr. of med. necessity, post-op x-ray(s)
D3999	unspecified endodontic procedure, by report	1 - 20	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
"Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes, any provider.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances."

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4210, D4211) every two years, 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	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4210, D4211) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4230	anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant	13 - 20		Yes	Limit to one service of (D4230, D4231) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4231	anatomical crown exposure - one to three teeth or bounded tooth spaces per	13 - 20		Yes	Limit to one service of (D4230, D4231) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
	quadrant					
D4240	gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4240, D4241) every two years, per patient, per quadrant.	narr of med necessity & full mouth xrays
D4241	gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4240, D4241) every two years, per patient, per quadrant.	narr of med necessity & full mouth x-rays
D4245	apically positioned flap	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service per two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4249	clinical crown lengthening – hard tissue	13 - 20	Teeth 1 - 32	Yes	Limit to one service per lifetime, per patient, per tooth.	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	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4260, D4261) per year, per patient, per quadrant.	full mouth x-rays, 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	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4260, D4261) per year, per patient, per quadrant.	full mouth x-rays, perio charting & narrative
D4266	guided tissue regenerate-resorbable barrier, per site, per tooth	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4267	guided tissue regeneration – non-resorbable barrier,	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
	per site, per tooth					ray(s)
D4270	pedicle soft tissue graft procedure	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4273	subepithelial connective tissue graft procedure	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4274	distal or proximal wedge procedure	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4275	soft tissue allograft	13 - 20	Teeth 1 - 32	Yes	Limit to one service per day, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4276	combined connective tissue and double pedicle graft	13 - 20	Teeth 1 - 32	Yes	Limit to one service per two years, 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	13 - 20	Teeth 1 - 32, 51 - 82	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	13 - 20	Teeth 1 - 32, 51 - 82	Yes	Must be billed on the same DOS 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	13 - 20	Teeth 1 - 32	Yes	Limited to three services of (D4283, D4285) per day, per provider, per tooth. D4283 is an add-on code and must be billed along with procedure code D4273.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
	same graft site					
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	13 - 20	Teeth 1 - 32	Yes	Limited to three services of (D4283, D4285) per day, per provider, per tooth. D4283 is an add-on code and must be billed along with procedure code D4273.	narr. of med. necessity, pre-op x-ray(s)
D4320	provision splinting - intracoronal	1 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service of (D4230, D4321) per lifetime, per patient, per arch.	narr. of med. necessity, pre-op x-ray(s)
D4321	provision splinting - extracoronal	1 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service of (D4230, D4321) per lifetime, per patient, per arch.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planning - four or more teeth per quadrant	13 - 20	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 x-rays, perio charting & narrative
D4342	periodontal scaling and root planning - one to three teeth per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	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.	full mouth x-rays, perio charting & narrative
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	13 - 20		Yes	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes (D4210, D4211, D4230, D4231, D4240, D4241, D4245, D4249, D4260, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4278, D4283, D4285, D4320, D4321, D4381, D4910, D4920, D4999) or with D0150, D0160, D0180, D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4381	localized delivery of antimicrobial agents	13 - 20	Teeth 1 - 32	Yes	Limit one service every two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4910	periodontal maintenance procedures	13 - 20		Yes	Limit of two services per year, 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)	13 - 20		No		
D4999	unspecified periodontal procedure, by report	13 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
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 retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	3 - 20	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	3 - 20	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient.	pre-operative x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5130	immediate denture - maxillary	13 - 20	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient. One of (D5130) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	13 - 20	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient. One of (D5140) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	6 - 20		Yes	Limit one service of (D5211, D5213, D5864) every five years, per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	6 - 20		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	9 - 20		Yes	Limit one service of (D5211, D5213, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	9 - 20		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	3 - 20		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	3 - 20		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	6 - 20		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	6 - 20		No	Limit one service per year, per patient. Not covered within 6 months of placement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	3 - 20	Per Arch (02, LA)	No	Cost of repairs cannot exceed replacement costs.	
D5512	repair broken complete denture base, maxillary	3 - 20	Per Arch (01, UA)	No	Cost of repairs cannot exceed replacement costs.	
D5520	replace missing or broken teeth - complete denture (each tooth)	3 - 20	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	
D5611	repair resin partial denture base, mandibular	3 - 20	Teeth 17 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5612	repair resin partial denture base, maxillary	3 - 20	Teeth 1 - 16	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5630	repair or replace broken clasp	6 - 20	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5640	replace broken teeth-per tooth	6 - 20	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5650	add tooth to existing partial denture	6 - 20	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5660	add clasp to existing partial denture	6 - 20		No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	6 - 20		No	Limit one service every three years, 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)	6 - 20		No	Limit one service every three years, per patient. Not covered within 6 months of placement. Denied with D5211, D5213, D5281, D5640.	
D5710	rebase complete maxillary denture	4 - 20		No	Limit one service of (D5710, D5730, D5750) every three years, per patient. Not covered within 6 months of placement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5711	rebase complete mandibular denture	4 - 20		No	Limit one service of (D5711, D5731, D5751) every three years, per patient. Not covered within 6 months of placement.	
D5720	rebase maxillary partial denture	7 - 20		No	Limit one service of (D5720, D5740, D5760) every three years, per patient. Not covered within 6 months of placement.	
D5721	rebase mandibular partial denture	7 - 20		No	Limit one service of (D5721, D5741, D5761) every three years, per patient. Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (chairside)	4 - 20		No	Limit one service of (D5710, D5730, D5750) every three years, per patient. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	4 - 20		No	Limit one service of (D5711, D5731, D5751) every three years, per patient. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	7 - 20		No	Limit one service of (D5720, D5740, D5760) every three years, per patient. Not covered within 6 months of placement.	
D5741	reline mandibular partial denture (chairside)	7 - 20		No	Limit one service of (D5721, D5741, D5761) every three years, per patient. Not covered within 6 months of placement.	
D5750	reline complete maxillary denture (laboratory)	4 - 20		No	Limit one service of (D5710, D5730, D5750) every three years, per patient. Not covered within 6 months of placement.	
D5751	reline complete mandibular denture (laboratory)	4 - 20		No	Limit one service of (D5711, D5731, D5751) every three years, per patient. Not covered within 6 months of placement.	
D5760	reline maxillary partial denture (laboratory)	7 - 20		No	Limit one service of (D5720, D5740, D5760) every three years, per patient. Not covered within 6 months of placement.	
D5761	reline mandibular partial denture (laboratory)	7 - 20		No	Limit one service of (D5721, D5741, D5761) every three years, per patient. Not covered within 6 months of placement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5810	interim complete denture-maxillary	3 - 20		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5811	interim complete denture-mandibular	3 - 20		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (maxillary)	3 - 20		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5821	interim partial denture-mandibular	3 - 20		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5850	tissue conditioning, maxillary	3 - 20		No		
D5851	tissue conditioning, mandibular	3 - 20		No		
D5862	precision attachment, by report	4 - 20	Teeth 1 - 32	No		
D5863	Overdenture - complete maxillary	4 - 20	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5864	Overdenture - partial maxillary	4 - 20		Yes	Limit one service of (D5211, D5213, D5864) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5865	Overdenture - complete mandibular	4 - 20	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5866	unspecified removable prosthodontic procedure, by report	4 - 20		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5899	unspecified removable prosthodontic procedure, by report	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5911	facial moulage (sectional)	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5912	facial moulage (complete)	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5913	nasal prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5914	auricular prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5915	orbital prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5916	ocular prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5919	facial prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5922	nasal septal prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5923	ocular prosthesis, interim	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5924	cranial prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5925	facial augment implant prosthesis	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5926	nasal prosthesis, replacement	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5927	auricular prosthesis, replace	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5928	orbital prosthesis, replace	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5929	facial prosthesis, replacement	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5932	obturator prosthesis, definitive	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5933	obturator prosthesis, modification	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5934	mandibular resection prosthesis with guide flange	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5935	mandibular resection prosthesis without guide flange	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5936	obturator prosthesis, interim	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5937	trismus appliance (not for TMD treatment)	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5951	feeding aid	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5952	speech aid prosthesis, pediatric	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5953	speech aid prosthesis, adult	13 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5954	palatal augment prosthesis	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5955	palatal lift prosthesis, definitive	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5958	palatal lift prosthesis, interim	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5959	palatal lift prosthesis, modification	0-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes		narrative of medical necessity
D5982	surgical stent	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5983	radiation carrier	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5984	radiation shield	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5985	radiation cone locator	1 - 20		Yes		narr. of med. necessity, pre and post-op x-ray(s)
D5986	fluoride gel carrier	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5987	commissure splint	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)
D5988	surgical splint	1 - 20		Yes	Not allowed within 6 months of delivery.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20		No	Limit one service every five years, per patient.	
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-20		No		
D5999	unspecified maxillofacial prosthesis, by report	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
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 retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6211	pontic-cast base metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6212	pontic - cast noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6240	pontic-porcelain fused-high noble	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6241	pontic-porcelain fused to base metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6242	pontic-porcelain fused-noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6250	pontic-resin with high noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6251	pontic-resin with base metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6252	pontic-resin with noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6545	retainer - cast metal fixed	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, 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	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6549	Resin retainer-For resin bonded fixed prosthesis	16 - 20	Teeth 1 - 32	No	Limit one service every five years, per patient.	
D6720	crown-resin with high noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6721	crown-resin with base metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6722	crown-resin with noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6740	retainer crown – porcelain/ceramic	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6750	crown-porcelain fused high noble	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6751	crown-porcelain fused to base metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6752	crown-porcelain fused noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6780	crown-3/4 cst high noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	16 - 20	Teeth 1 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6790	crown-full cast high noble	16 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6791	crown - full cast base metal	16 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6792	crown - full cast noble metal	16 - 20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (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) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6920	connector bar	16 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service every five years, per patient, per tooth.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	16 - 20		No	Not allowed within 6 months of initial placement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6940	stress breaker	16 - 20	Teeth 1 - 32	No	Limit one service every five years, per patient, per tooth.	
D6950	precision attachment	16 - 20	Teeth 1 - 32	No	Limit one service every five years, per patient, per tooth.	
D6980	fixed partial denture repair	16 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D6999	fixed prosthodontic procedure	16 - 20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
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 retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	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)	0-4	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5 - 20	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10 - 20	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	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	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth-soft tissue	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth-partially bony	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7240	removal of impacted tooth-completely bony	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7260	oroantral fistula closure	1 - 20	Teeth 1 - 16	Yes		narr. of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	1 - 20	Teeth 1 - 16	Yes	May not be paid for the same date of service as D7260.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	1 - 20	Teeth 1 - 32	No		
D7272	tooth transplantation (includes reimplantation from one site to another)	1 - 20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	1 - 20	Teeth 2-15, 18-31	Yes	D7280 will be denied unless billed with an authorized procedure code D7283, for the same tooth, on the same day, by the same provider.	narr. of med. necessity, full mouth x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7282	mobilization of erupted or malpositioned tooth to aid eruption	4 - 20	Teeth 1 - 32	No	May not be paid for the same date of service as D7280.	
D7283	placement of device to facilitate eruption of impacted tooth	1 - 20	Teeth 2-15, 18-31	Yes		narr. of med. necessity, full mouth x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	1 - 20		No		
D7286	incisional biopsy of oral tissue-soft	1 - 20		No		
D7290	surgical repositioning of teeth	1 - 20	Teeth 1 - 32	No		
D7291	transseptal fiberotomy, by report	4 - 20	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service per 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	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	1 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7350	vestibuloplasty - ridge extension	1 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7410	radical excision - lesion diameter up to 1.25cm	1 - 20		No		
D7411	excision of benign lesion greater than 1.25 cm	1 - 20		No		
D7413	excision of malignant lesion up to 1.25 cm	1 - 20		No		

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7414	excision of malignant lesion greater than 1.25 cm	1 - 20		No		
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	1 - 20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee.	
D7441	excision of malignant tumor – lesion diameter greater than 1.25cm	1 - 20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee.	
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	1 - 20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	1 - 20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7465	destruction of lesion(s) by physical or chemical method, by report	1 - 20		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7472	removal of torus palatinus	1 - 20		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Not allowed on same day as extraction.	
D7520	incision and drainage of abscess - extraoral soft tissue	1 - 20		No		

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	1 - 20		No		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	1 - 20		No		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	1 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	1 - 20		No		
D7670	alveolus stabilization of teeth, closed reduction splinting	1 - 20		No		
D7820	closed reduction dislocation	1 - 20		No		
D7880	occlusal orthotic device, by report	1 - 20		Yes	Limit one service every five years, per patient.	narrative of medical necessity
D7899	unspecified TMD therapy, by report	1 - 20		Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	1 - 20		No	D7910, D7911, and D7912 will deny if billed on the same date of service with any other D7000 series code.	
D7911	complicated suture-up to 5 cm	1 - 20		Yes	D7911, D7910, and D7912 will deny if billed on the same date of service with any other D7000 series code.	narrative of medical necessity
D7912	complex suture - greater than 5cm	1 - 20		Yes	D7912, D7910, and D7911 will deny if billed on the same date of service with any other D7000 series code.	narr. of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	1 - 20		Yes		narrative of medical necessity
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	1 - 20		Yes		photos, narrative/treatment plan

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7970	excision of hyperplastic tissue – per arch	1 - 20	Per Arch (01, 02, LA, UA)	Yes	Limit one service per lifetime, per patient, per arch.	narr. of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	1 - 20	Teeth 1 - 32	No	Limit one service per lifetime, per patient, per arch.	
D7972	surgical reduction of fibrous tuberosity	13 - 20	Teeth 1, 16, 17, 32	No	Limit of two services per lifetime, per patient. Not allowed with extraction of 1, 16, 17, or 32 on the same date of service. May not be paid in addition to D7971 for the same date of service.	narrative of medical necessity
D7980	surgical sialolithotomy	1 - 20		No		
D7983	closure of salivary fistula	1 - 20		No		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	1 - 20		Yes	Limit one service per lifetime, per patient. Not allowed by provider or office that placed the appliance.	narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	1 - 20		Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
Please see Appendix A-7 for the Texas Orthodontia Review Policy for additional information on definitions, case levels, criteria and requirements for submission. Comprehensive orthodontic services include all of the following: • Diagnostic workups • Banding • Initial brackets • Replacement brackets • Monthly visits • Initial retainers • Special orthodontic treatment appliance(s)"
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-6		Yes	Limit one service of (D8010, D8020) per lifetime, per patient. No more than 10 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8020	limited orthodontic treatment of the transitional dentition	6-9		Yes	Limit one service of (D8010, D8020) per lifetime, per patient. No more than 10 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8050	interceptive orthodontic treatment of the primary dentition	0-12		Yes	Limit one service of (D8050, D8060, D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8060	interceptive orthodontic treatment of the transitional dentition	6-13		Yes	Limit one service per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Orthodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D8070	comprehensive orthodontic treatment of the transitional dentition	10-12		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8080	comprehensive orthodontic treatment of the adolescent dentition	12-20		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8090	comprehensive orthodontic treatment of the adult dentition	12-20		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-12		Yes	Limit two services of (D8210, D8220) per lifetime, per patient. One per arch. Pre-authorization is required.	narrative of medical necessity
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-12		Yes	Limit two services of (D8210, D8220) per lifetime, per patient. One per arch. Pre-authorization is required.	narrative of medical necessity
D8670	periodic orthodontic treatment visit	0-20		Yes	Limit one service per 21 days, per patient. Pre-authorization is required.	models, pano, cephalo, photos
D8680	orthodontic retention (removal of appliances)	0-20		Yes	Limit one service per lifetime, per patient. Pre-authorization is required.	models, pano, cephalo, photos

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit A Benefits Covered for TX Medicaid Child (Under 21)
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.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment 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.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**
Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM. **For D9220:** Provider must indicate the client's medical diagnosis of intellectual disability described as mild, moderate, severe, profound, or unspecified by using the most appropriate diagnosis code in the diagnosis code field of the claim form, or the provider must indicate that the client is ICF-IID eligible in the Remarks field of the claim form. Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: A current physician statement detailing the client's the intellectual disability. The statement must be signed and dated within one year prior to the dental behavior management. A description of the service performed (including the specific problem and the behavior management technique applied). Personnel and supplies required to provide the behavioral management. The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services

Code	Brief Description	Age Limitation	Teeth Covered	Review Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	Emergency service only. The type of treatment rendered must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Not allowed for prescriptions or medication.	Narrative of medical necessity
D9120	fixed partial denture sectioning	1 - 20	Teeth 1 - 32	No		

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9210	local anesthesia not in conjuction with operative or surgical procedures	1 - 20		Yes	Code D9210 is not to be billed in conjunction with operative or surgical procedures, the administration of local anesthetic is inclusive in operative and surgical procedures. Not allowed with D9248. Pre-payment review required.	narrative of medical necessity
D9211	regional block anesthesia	1 - 12		No	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Not allowed with D9248.	
D9211	regional block anesthesia	13 - 20		No	Not allowed with D9248.	
D9212	trigeminal division block anesthesia	1 - 12		No	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Not allowed with D9248.	
D9212	trigeminal division block anesthesia	13 - 20		No	Not allowed with D9248.	
D9222	deep sedation/general anesthesia – first 15 minutes	1-6		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9222	deep sedation/general anesthesia – first 15 minutes	7-12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243	narrative of medical necessity
D9222	deep sedation/general anesthesia – first 15 minutes	13 - 20		Yes	Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or 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	1-6		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9223	deep sedation/general anesthesia - each subsequent 15- minute increment	7 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or 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	13 - 20		Yes	Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	1 - 20		No	Limit one service per day, per patient. Not allowed with D9222, D9223, D9239, D9243 and D9248 on same date of service.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	1 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Limit one service per day, per patient ages 1 and above. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	13 - 20		Yes	Limit one service per day, per patient ages 1 and above. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or 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	1 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Limit five services per day, per patient. It is to be billed in 15-minute increments totaling one and one-half hours per day. Not allowed on same day as D9230 or 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	13 - 20		Yes	Limit five services per day, per patient. It is to be billed in 15-minute increments totaling one and one-half hours per day. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity
D9248	non-intravenous moderate (conscious) sedation	1 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 2, 3, or 4 – Pediatric, TX Anesthesia Level 2, 3, or 4 – High Risk) to perform this procedure. Limit two services per year, per patient. Denied when submitted for the same date of service as procedure code D9420, any provider. Not allowed with D9222, D9223 D9230, D9239 and D9243. Pre authorization is required.	narr. of med. necessity, pre-op x-ray(s)
D9248	non-intravenous moderate (conscious) sedation	13 - 20		Yes	Limit two services per year, per patient. Denied when submitted for the same date of service as procedure code D9420, any provider. Not allowed with D9222, D9223 D9230, D9239 and D9243. Pre-authorization is required.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 - 20		No	An oral evaluation by specialist of any type who is also providing restorative or surgical services must be submitted as D0160.	
D9410	house/extended care facility call	1 - 20		No	Should be billed as D0160 for specialist who is providing treatment.	
D9420	hospital or ambulatory surgical center call	1 - 20		No	Limit two services per year, per patient, per tooth. Dental hospital calls (procedure code D9420) are currently limited to twice per rolling year, per member, any provider. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the member's record and may be subject to retrospective review and recoupment.	narrative of medical necessity
D9430	office visit for observation -no other services performed	1 - 20		No	No other services allowed. Not to be used for post-operative care.	
D9440	office visit - after regularly scheduled hours	1 - 20		No	Not to be used for post-operative care.	narrative of medical necessity
D9610	therapeutic drug injection, by report	1 - 20		Yes	Limit one service of (D9610, D9612) per day per patient. Not allowed with D9220 or D9221. May not be submitted with code D9248.	Description of drugs with claim
D9612	therapeutic drug injection - 2 or more medications by report	1 - 20		Yes	Limit one service of (D9610, D9612) per day per patient. Not allowed with D9220 or D9221.	Description of drugs with claim
D9630	other drugs and/or medicaments, by report	1 - 20		Yes	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. Not allowed with D9220, D9221, D9230, D9241, D9248, D9610 or D9920.	narrative of medical necessity
D9910	application of desensitizing medicament	18 - 20		No	Not to be used as a base or a liner.	
D9920	behavior management, by report	0-20		Yes	Limit one service per day, per patient. Denied if billed with D9248, D0120-D0180, D1110, D1120 or D0210-D0363.	narrative of medical necessity

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9930	treatment of complications (post-surgical) – unusual circumstances, by report	1 - 20		Yes		narrative of medical necessity
D9944	occlusal guard – hard appliance, full arch	16 - 20		Yes		narrative of medical necessity
D9950	occlusion analysis-mounted case	13 - 20		Yes		narrative of medical necessity
D9951	occlusal adjustment - limited	13 - 20		No	Limit one service per year, per provider.	
D9952	occlusal adjustment - complete	13 - 20		No	Limit one service per lifetime, per provider.	
D9970	enamel micro-abrasion	13 - 20	Teeth 1 - 32	No	Limit One service per day, per provider.	
D9974	internal bleaching - per tooth	13 - 20	Teeth 1 - 32	No		Narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	1 - 20				narrative of medical necessity

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)
Covered Dental Services are subject to a $564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.
CHIP Members who have exhausted the $564 annual benefit limit continue to receive the following Covered Dental Services in excess of $564 annual benefit maximum:
(1) the diagnostic and preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule; and
(2) other Medically Necessary Covered Dental Services approved by the Dental Contractor through a prior authorization process. These services must be necessary to allow a CHIP Member to return to normal, pain and infection-free oral functioning. Typically, this includes:
- Services related to the relief of significant pain or to eliminate acute infection;
- Services related to treat traumatic clinical conditions;
- Services that allow the CHIP Member to attain the basic human functions (e.g. eating, speech, etc.); and
- Services that prevent a condition from seriously jeopardizing the CHIP Member's health/functioning or deteriorating in an imminent timeframe to a more serious and costly dental problem.
Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.
All radiographs, must be of good diagnostic quality, include member's full name, date films taken, and identify the patients left and right side. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.
Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment 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.
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	0-18		No	Limited to one every six months by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0150, by the same provider. Codes D0120, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	0-18		No	Limited of one service per day, per provider or two services per day, per patient. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0150 per provider. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with routine dental services. Document of Medical Necessity must be indicated on the claim.	
D0150	comprehensive oral evaluation - new or established patient	0-18		No	Limit of one service per lifetime, per provider. Codes D0120 and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0210	intraoral - complete series of radiographic images	2-5		Yes	Limit of one service of (D0210, D0330) every three years per provider OR location. Narrative of medical necessity and x-ray.	narr. of med. necessity, pre-op x-ray(s)
D0210	intraoral - complete series of radiographic images	6-18		No	Limit of one service of (D0210, D0330) per three years per provider OR location	
D0220	intraoral - periapical first radiographic image	1-18		No	Limit of one service per day, per provider OR location.	
D0230	intraoral - periapical each additional radiographic image	1-18		No		
D0270	bitewing - single radiographic image	1		Yes	Limited to one service of (D0270, D0272, D0274) per day, per provider OR location. Narrative of medical necessity and x-ray showing fully erupted primary first molar.	narr. of med. necessity, pre-op x-ray(s)
D0270	bitewing - single radiographic image	2 - 18		No	Limit one service of (D0270, D0272, D0274) per day, per provider OR location.	
D0272	bitewings - two radiographic images	1		Yes	Limit one service of (D0270, D0272, D0274) per day, per provider OR location. Narrative of medical necessity and x-rays showing fully erupted left and right primary first molars.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Diagnostic						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	2 - 18		No	Limit one service of (D0270, D0272, D0274) per day, per provider OR location. Limit one service of D0210, D0272 per day, per patient.	
D0274	bitewings - four radiographic images	2-9		Yes	Limit one service of (D0270, D0272, D0274) per day, per provider OR location. Limit one service of D0210, D0274 per day, per patient. Narrative of medical necessity and x-rays showing fully erupted left and right second permanent molars.	narr. of med. necessity, pre-op x-ray(s)
D0274	bitewings - four radiographic images	10 - 18		No	Limit one service of (D0270, D0272, D0274) per day, per provider OR location. Limit one service of D0210, D0274 per day, per patient.	
D0330	panoramic radiographic image	5		Yes	Limit one service of (D0210, D0330) every five years, per provider OR location. Limit one service of D0210, D0330 per day, per patient. Narrative of medical necessity and x-ray.	narr. of med. necessity, pre-op x-ray(s)
D0330	panoramic radiographic image	6 - 18		No	Limit one service of (D0210, D0330) every five years, per provider OR location. Limit one service of D0210, D0330 per day, per patient.	
D0601	Caries risk assessment and documentation, with a finding of low risk	0-18		No	Codes D0120 and 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	0-18		No	Codes D0120 and 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	0-18		No	Codes D0120 and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)						
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment 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.						
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.						
Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13-18		No	Limit one service of (D1110, D1120) per six months, per patient. D1110 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Any provider.	
D1120	prophylaxis - child	0-12		No	Limit one service of (D1110, D1120) per six months, per patient. D1120 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Any provider.	
D1206	topical application of fluoride varnish	0-18		No	Limit one service of (D1206, D1208) per six months, per patient. D1206 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1206 will be denied	
D1208	topical application of fluoride - excluding varnish	0-18		No	Limit one service of (D1206, D1208) per six months, per patient. D1208 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Any provider.	
D1351	sealant - per tooth	0-18	Teeth 2 - 5, 12 - 15, 18, 19, 30, 31	No	Limit one service per lifetime, per patient, per tooth. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code.	
D1354	interim caries arresting medicament application – per tooth	6 months-6 years	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		D1354 is limited to two applications, per lifetime of tooth, with 30 days minimum separation between application dates. Not allowed on the same day as D1206 or D1208. D1354 is not allowed on teeth which have had D2000 series procedure{s) in prior 12 months. D2000 series procedures are not allowed for 30 days after the application of D1354. D1354 must be deemed medically necessary by Main Dental Home provider.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1510	space maintainer-fixed-unilateral – Per quadrant	1 - 18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit one service of (D1510, D1520) every two years, per patient, per quadrant.	
D1516	space maintainer – fixed – bilateral, maxillary	1 - 18	Per Arch (01, UA)	No	Limit one service of (D1516 or D1526) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1517	space maintainer – fixed – bilateral, mandibular	1 - 18	Per Arch (02, LA)	No	Limit one service of (D1517 or D1527) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1520	Space maintainer-removable-unilateral	1 - 18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit one service of (D1510, D1520) every two years, per patient, per quadrant.	
D1526	space maintainer – removable – bilateral, maxillary	1 - 18	Per Arch (01, UA)	No	Limit one service of (D1516 or D1526) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1527	space maintainer – removable – bilateral, mandibular	1 - 18	Per Arch (02, LA)	No	Limit one service of (D1517 or D1527) every two years, per patient, per arch. Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1575	distal shoe space maintainer – fixed - unilateral	3-7	Teeth A, J, K, T	No	Limit one service of (D1517 or D1527) per Lifetime Per patient per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)
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.
BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.
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 retrospective pre-payment 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.
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 following codes require prior authorization for all ages: D2720, D2722, D2740, D2750, D2751, D2752, D2790, and D2791.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
A replacement of an identical restorative service in less than 36 months by the same office is not considered the standard of care for quality by DentaQuest. If there are special circumstances requiring this repeat service, please send in a prior authorization request along with a narrative establishing medical necessity.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	1-18	Teeth 1 - 32, A - T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	1-18	Teeth 1 - 32, A - T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite – two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	1-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	1 - 18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	1 - 18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per year, per patient, per tooth, per surface.	
D2710	crown - resin-based composite (indirect)	13 - 18	Teeth 1 - 32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	pre-operative x-ray(s)
D2720	crown-resin with high noble metal	13 - 18	Teeth 1 - 32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre op x-ray(s)
D2721	crown - resin with predominantly base metal	13 - 18	Teeth 1 - 32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	13 - 18	Teeth 1 - 32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic	13 - 18	Teeth 4-13, 20-29	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2750	crown - porcelain fused to high noble metal	13 - 18	Teeth 4-13, 20-29	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	13 - 18	Teeth 4-13, 20-29	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2752	crown - porcelain fused to noble metal	13 - 18	Teeth 4-13, 20-29	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2790	crown - full cast high noble metal	13 - 18	Teeth 1–5, 12–21, 28–32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2791	crown - full cast predominantly base metal	13 - 18	Teeth 1–5, 12–21, 28–32	Yes	Limit one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791) every five years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	0-18	Teeth A - T	No	Limit to one (D2934 or D2930) per lifetime, per patient, per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	1 - 18	Teeth 1–32	No	Limit one service per lifetime, per patient, per tooth.	
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	0-18	Teeth C-H, M-R	No	Limit to one (D2934 or D2930) per lifetime, per patient, per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)
Payment for conventional root canal treatment is limited to treatment of permanent teeth.
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 retrospective pre-payment 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.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth A - T	No	Limit one service per lifetime, per patient, per tooth.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 2 - 15, 18 - 31	No	Limit one service of (D3220, D3230, D3240, D3310, D3320, D3330) every 6 months, per patient, per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 - 18	Teeth C - H, M - R	No	Limit one service per lifetime, per patient, per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others
without written permission. ©Copyright 2020. All rights reserved.

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 - 18	Teeth A, B, I - L, S, T	No	Limit one service per lifetime, per patient, per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6 - 18	Teeth 6 - 11, 22 - 27	No	Limit one service per lifetime, per patient, per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	6 - 18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Limit one service per lifetime, per patient, per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	6 - 18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Limit one service per lifetime, per patient, per tooth.	

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)
Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes, any provider.
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment 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.
When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty – four or more contiguous	13 - 18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service every two years, per patient, per quadrant. Limit One service of (D4210, D4355,) per day, per patient, per quadrant. Limit one service of (D1110, D1120D1206, D1208, D1351, D1510, D1520,) per day, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planning - four or more teeth per quadrant	13 - 18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	D4341 is denied if provided within 21 days of D4355. D4341 and are denied when submitted for the same DOS as other D4000 series codes, except with D4341 or with D1110, D1120, D1206, D1208, D1351, D1510, D1520, or D1525, Any Provider.	Full mouth xrays, perio charting & narrative
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	13 - 18		Yes	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes D4210, or with D0150, D1110, D1120, D1206, D1208, D1351, D1510, D1520.	narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)
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 retrospective pre-payment 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.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	3 - 18	Per Arch (01, UA)	Yes	Limit one service every five years, per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	3 - 18	Per Arch (02, LA)	Yes	Limit one service every five years, per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	6 - 18		Yes	Limit one service of (D5211, D5213) every five years, per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	6 - 18		Yes	Limit one service of (D5212, D5214) every five years, per patient.	pre-operative x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others
without written permission. ©Copyright 2020. All rights reserved.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials rests and teeth)	9 - 18		Yes	Limit one service of (D5211, D5213) every five years, per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	9 - 18		Yes	Limit one service of (D5212, D5214) every five years, per patient.	pre-operative x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)						
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 or demonstrated malocclusion causing a shifting of existing dentition.						
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 retrospective pre-payment 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.						
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.						
Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-4	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5 - 18	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10 - 18	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 18	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)
D7220	removal of impacted tooth-soft tissue	1 - 18	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	1 - 18	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	1 - 18	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)

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.

Exhibit B Benefits Covered for TX CHIP (Child Under 19)						
"Please see Appendix A-7 for the Texas Orthodontia Review Policy for additional information on definitions, case levels, criteria and requirements for submission.						
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances."						
Orthodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-18		Yes	Limited to pre- and post-surgical orthodontic services to treat craniofacial anomalies requiring surgical intervention.	
D8020	limited orthodontic treatment of the transitional dentition	0-18		Yes		
D8050	interceptive orthodontic treatment of the primary dentition	0-18		Yes		
D8060	interceptive orthodontic treatment of the transitional dentition	0-18		Yes	Limit one service per lifetime, per patient.	
D8070	comprehensive orthodontic treatment of the transitional dentition	10-12		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	Models, pano, Cephalo, photos
D8080	comprehensive orthodontic treatment of the adolescent dentition	12-18		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	Models, pano, Cephalo, photos
D8090	comprehensive orthodontic treatment of the adult dentition	12-18		Yes	Limit one service per lifetime, per patient. No more than 48 adjustments (D8670) allowed. Pre-authorization is required.	Models, pano, Cephalo, photos
D8670	periodic orthodontic treatment visit	10-18		Yes	Limit one service per 21 days per patient. Pre-authorization is required.	Models, pano, Cephalo, photos
D8680	orthodontic retention (removal of appliances)	10-18		Yes	Limit one service per lifetime, per patient. Pre-authorization is required.	Models, pano, Cephalo, photos

This document contains proprietary and confidential information and may not be disclosed to others without written permission. ©Copyright 2020. All rights reserved.