



## **DentaQuest, LLC**

### **Office Reference Manual**

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

## **Blue Cross Blue Shield of Michigan**

### **Healthy Kids Dental**

**P.O. Box 491  
Milwaukee, WI 53201-0491  
844-876-7917**

[www.dentaquest.com](http://www.dentaquest.com)

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**DentaQuest, LLC**  
**Address and Telephone Numbers**

**PROVIDER SERVICES**

**Claims or Pre-Services should be sent to:**

Blue Cross Blue Shield of Michigan  
P.O. Box 491  
Milwaukee, WI 53201-0491

Phone: 844.876.7917

Fax numbers:

General Inquiries: 262.834.3450

Claims/Payment Issues: 262.834.3589

Claims questions:

[denclaims@DentaQuest.com](mailto:denclaims@DentaQuest.com)

Eligibility or Benefit Questions:

[denelig.benefits@DentaQuest.com](mailto:denelig.benefits@DentaQuest.com)

**General inquiries:**

DentaQuest  
P.O. Box 2906  
Milwaukee, WI 53201-2906  
OR  
11100 W. Liberty Drive  
Milwaukee, WI 55324

**Customer Service/Member Services:**

Member Services: 800.936.0935

Email: [www.bcbsm.com/healthykids](http://www.bcbsm.com/healthykids)

**TDD (Hearing Impaired):**

800.466.7566 or

TTY: 711

**Fraud Hotline:**

800.237.9139

For additional provider related issues,

**Credentialing:**

DentaQuest, LLC  
Attn: Credentialing Dept.  
P.O. Box 2906  
Milwaukee, WI 53201-2906

Credentialing Hotline: 800.233.1468

Fax: 262.241.4077

**Complaints and Grievances:**

DentaQuest, LLC  
Attn: BCBSM Complaints & Grievances  
P.O. Box 491  
Milwaukee, WI 53201-0491

Phone: 844.876.7917

**Electronic Claims should be sent:**

Direct entry on the web – [www.dentaquest.com](http://www.dentaquest.com)  
or <http://provideraccess.dentaquest.com> Or,  
Via Clearinghouse – Payor ID BBMDQ  
Include address on electronic claims –  
DentaQuest, LLC  
Attn: BCBSM  
P.O. Box 491  
Milwaukee, WI 53201-0491

## CHAMPS: Medicaid Enrollment Requirement:

Healthy Kids Dental Providers **MUST ENROLL** in  
Community Health Automated Medicaid Processing System -**CHAMPS**

Enroll online: <https://milogintp.michigan.gov>

For questions or assistance contact:  
**Medicaid Provider Helpline**  
1-800-292-2550

Healthy Kids Dental Providers must be enrolled into the Community Health Automated Medicaid Processing System (CHAMPS), operated by MDHHS, prior to being authorized, approved, or reimbursed for services through the Medicaid program.

This requirement applies even to those who do not bill directly to the state, but receive payment through Medicaid managed care plans such as Healthy Kids Dental.

### To enroll in CHAMPS:

- Visit the web portal for CHAMPS at <https://milogintp.michigan.gov>
- Apply for a user name and password, and then subscribe to the CHAMPS link

### To review instructions on this process:

- Visit [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs) -Select "Providers" from the left side menu, then the "Providers" link
- Click "CHAMPS" logo
- Scroll down to "Accessing the CHAMPS System" to find the "SSO Instructions" link

CHAMPS is a NPI-based system. Online enrollment takes 15–20 minutes to complete. It can take 3–4 weeks to receive final approval. You will receive a letter confirming enrollment.

If you have any questions or need assistance with enrollment, please contact the Medicaid Provider Help Line 1.800.292.2550 or email [ProviderEnrollment@michigan.gov](mailto:ProviderEnrollment@michigan.gov) or [providersupport@michigan.gov](mailto:providersupport@michigan.gov).

## Cultural Competency Training Requirement

As oral health disparities among cultural minority groups persist in our country, culturally and linguistically appropriate services (CLAS) are increasingly recognized as an important strategy for improving quality of care to diverse populations. **Providers are contractually obligated to participate in a Cultural Competency Training program on an annual basis.**

For providers that wish to complete training there are a number of online resources, including trainings from the U.S. Department of Health and Human Services <https://www.hhs.gov/programs/education-and-training/index.html> This free e-learning program will equip you with the knowledge, skills, and awareness to best deliver oral health services to all patients, regardless of cultural or linguistic background.

Although DentaQuest does not mandate nor require providers to complete this or any specific related training; our obligation is to ensure our providers are providing care in a culturally-sensitive manner. DentaQuest requires providers to verify that they have participated in a Cultural Competency Training Program. A quarterly survey is mailed to participating network providers to verify that they have taken a Cultural Competency Training program and responses are tracked in our system.

### Fraud, Waste/Error and Abuse and General Compliance Training Requirement

All DentaQuest contracted providers are required to complete Fraud, Waste/Error and Abuse Training and General Compliance Program to prevent, detect, and correct the incidence of non-compliance with CMS requirements and the incidence of fraud, waste/error and abuse within 90 days of hire/contracting and annually thereafter. Training must be documented by the provider office and maintained for 10 years.

Providers will receive communications on a regular basis regarding Fraud, Waste, and Abuse, training and contract requirements.

CMS provides a variety of online educational resources related to Medicaid compliance requirements and best practices to support dental offices in the fight against fraud, waste/error and abuse at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Dental-Resources>

### Reporting Fraud, Waste/Error & Abuse or Misuse of Services

Report fraud, waste/error and abuse in the following ways:



DentaQuest Fraud Hotline: 800.237.9139 or Anonymous hotline: 1-866-654-3433



Blue Cross Blue Shield of Michigan  
P.O. Box 491  
Milwaukee, WI 53201-0491

You can also report fraud, waste/error and abuse directly to the Michigan Department of Health and Human Services using the following methods:



Michigan Department of Health and Human Services  
Office of Inspector General  
P.O. Box 30062  
Lansing, MI 48909



1-855-MIFRAUD (643-7283) or  [www.michigan.gov/fraud](http://www.michigan.gov/fraud)

You can also visit <https://www.michigan.gov/mdhhs> to complete the **Medicaid Fraud and Abuse Online Complaint Form**.

### Healthy Kids Dental Appointment and Timely Access to Care Standards

Type of care	Length of time
Emergency dental services	Immediately, 24/7
Urgent care	Within 48 hours
Routine care	Within 21 business days of request
Preventive services	Within six weeks of request

Initial appointment

Within eight weeks of request



## DentaQuest, LLC

### Statement of Members Rights and Responsibilities

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

Providers must take Members' rights into account when providing services as outlined in 42 CFR 438.100. Providers must ensure Members are not denied a covered service or availability of a facility or provider identified in the BCBSM Healthy Kids Dental contract with the State of Michigan. Providers must not intentionally segregate Members in any way from other persons receiving dental services, and must offer hours of operation that are no less than offered to commercial or other enrollees.

The following is a statement of Member's rights and responsibilities.

1. All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.
2. All Members have a right to respectful and competent treatment regardless of race, color, religion, gender, sexual preference, veteran status, disability, or national origin.
3. All Members have the right to know the identity and professional status of all persons providing their oral health care services.
4. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.
5. All Members have the right to fully participate in decisions concerning their dental care after receiving sufficient information to enable them to give informed consent before beginning any procedure and/or treatment.
6. All Members have a right to receive Culturally and Linguistically Appropriate Services.
7. All Members have a right to confidentiality.
8. All Members have a right to be furnished with dental services consistent with the Contract, Michigan Medicaid State and federal regulations and the Medicaid Provider Manual.
9. All Members have a right to be free from other discrimination prohibited by Michigan Medicaid State and federal regulations and the Medicaid Provider Manual.
10. All Members have the right to accept or refuse participation in research and educational projects affecting their care and/or treatment.
11. All Members have the right to refuse treatment, drugs or other procedures to the extent permitted by law and to be made aware of potential medical consequences of refusing treatment.

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12. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed and presented in a manner consistent to the Member's condition and ability to understand.
  13. All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.
  14. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request a second opinion or external review, including a State Fair Hearing.
  15. All Members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.
  16. All Members have the right to be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on use of restraints and seclusions.
  17. All Members have the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.524 and 45 CFR 164.526.
  18. All Members have the right to have their dentist advise and advocate on their behalf regarding dental care and treatment options, as well as the risks, benefits, and consequences of treatment or non-treatment
  19. All Members have the right to be furnished dental care services in accordance with access and quality standards.
  20. All Members have the right to be free to exercise all rights and that by exercising those rights, the Enrollee shall not be adversely treated by the Department, DentaQuest, and Participating Providers.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.
2. All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
3. All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.
4. All Members have the responsibility of being considerate and cooperative in dealing with Plan staff.
5. All Members have the responsibility of scheduling appointments and arriving at their provider's office in time for scheduled visits. Members also have the responsibility to notify their provider's office within twenty-four (24) hours if they must cancel or will be late for a scheduled appointment.
6. All Members have the responsibility of designating an individual to act on their behalf and to authorize treatment in the event of incapacity.
7. All Members have the responsibility of reading and being aware of material distributed by the plan explaining policies and procedures regarding services and benefits.



## DentaQuest, LLC

### Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.
2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.
7. To be informed of the status of their credentialing or recredentialing application, upon request.
8. Request copies of DentaQuest policies and procedures by contacting Provider Services at 844-876-7917.

Likewise:

1. All providers have the responsibility to be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of the member.
2. All the providers have the responsibility to understand and comply with obligations under Michigan Medicaid State or Federal laws and the Medicaid Provider Manual to assist members with skilled interpreters.
3. All providers have the responsibility to submit claims for services rendered to BCBSM Healthy Kids Dental members. Providers must not balance bill, charge, collect deposit from, or seek any other compensation from members for covered services.
4. Participating practices are required to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, the "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists.
5. Providers shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. Per the Provider Agreement, provider must certify that no such excluded person will provide such services under the Agreement and no such excluded persons will be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Members. If Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider must

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immediately remove the Provider Related Party from any work related directly or indirectly to the Plan, and take all corrective actions required under applicable laws, rules or regulations.

6. Additionally, Provider shall notify DentaQuest immediately if Provider has lost any required license or state or federal approval, or been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et seq., or has been terminated from participation under Medicare, the Michigan Medicaid program, or another state's Medicaid program, except as permitted under 42 C.F.R. § 1001.1801 and § 1001.1901. [Sections 2.7.3.5.1 and 5.3.4 of Three-Way Contract.



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## DentaQuest, LLC

### Member Confidentiality and Release of Information

As a reminder to all providers, information from members' medical records and from physicians or hospitals must be kept confidential in accordance with Federal and Michigan Medicaid State law and per the Medicaid Provider Manual. We recognize that members have the right to have their health and medical information kept confidential, and we are committed to protecting access to our members' medical information. We have defined confidential information in our policy as:

1. Clinical information communicated to a physician, or other health care provider, in his/her professional capacity, included in the medical record and directly related to a member's diagnosis and treatment.
2. Data included in the computer or system that is directly related to member's diagnosis and treatment, such as claims information, information collected in the course of Utilization/ Case Management or other processes.
3. Member-identifiable secondary health information abstracted from the medical records/ computer database for indexes and statistics.
4. Member information collected through the enrollment process or generated through Marketing.

A properly completed authorization signed by the member is required for release of all health information except:

- as required by Federal or Michigan Medicaid State laws, the Medicaid Provider Manual, court orders, or subpoenas
- for release to another health care provider currently involved in the care of the member
- as outlined in the member's individual or group contract; and
- contractual obligations related to Quality Improvement or Utilization Management analysis.

The following are examples of some of the other situations your office may encounter on a day-to-day basis with some suggestions on how to maintain member confidentiality in these situations:

- **Telephone inquiries.** Avoid disclosing confidential patient information over the telephone because you have no idea who you are actually speaking with. Anyone can claim to be a physician or the patient's relative. If you have the patient's permission to release the information, you should obtain identifying information (e.g. medical record number, address, date of birth, etc.) before giving out any information over the telephone.
- **Phone messages to a patient's home or place of employment.** Leaving messages containing health information with another person or on an answering machine at the patient's home or at work may violate the patient's privacy, unless he/she has authorized you to do so. Leave your name, phone number and place of employment and ask the patient to return your call. If you know that you will need to call the patient back with advice or test results later in the day, ask the patient if you can leave a message on their answering machine or with another member of their family in the event they are not available. Document they gave you verbal consent to do so.
- **Reporting test results by mail.** All correspondence that contains health information (e.g. test results, appointment reminders) should be mailed to patients in a sealed envelope or post card that can be sealed in some manner.
- **Conversations in social settings.** Be aware of your surroundings. A patient's neighbor, relative or

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colleague may be in the elevator with you, sitting next to you at lunch, or following you out the door as you leave the office.

- **Store medical records in a secure manner.** Medical records, test results, consultant reports, etc. should not be left on desks or counters where unauthorized persons may see them. In addition, medical information on computer screens should not be visible to passersby. Always return your computer screen to the main menu or adjust the contrast if you have to leave your work area for any reason.

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

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### **Use of Your Information**

As a Participating Provider or a Participating Practice, you authorize DentaQuest, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this dental ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose Participating Practice's and Participating Provider's information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose such personal information to third parties, we require them to protect the privacy and security of this information.

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## Compliance Language

### Cooperation

Providers must cooperate fully with any investigation of alleged, suspected or detected violations of this manual, DentaQuest policies and procedures, Code of Conduct, Compliance Program standards, compliance issues, or applicable state or federal laws or regulations or remedial actions. Examples of a Providers non-compliance with the documents outlined above include, but aren't limited to:

- Billing for services other than what's provided;
- Refusing access to records that are essential to determine our liability; and
- Failure to maintain satisfactory documentation to support billings.

Cooperation is required for investigations whether conducted by DentaQuest staff or an outside firm. It is a violation of this manual to hide, alter, destroy, or otherwise modify or withhold documents subject to an investigation. During a government inquiry, never conceal, destroy, or alter documents or lie or mislead the government representative. Do not prevent any other employee or agent of DentaQuest from providing accurate information or obstruct, divert, or delay the communication of information or records to which government authorities may be entitled.

### Disciplinary Action

Providers must institute disciplinary standards and take appropriate action upon discovery of Fraud, Waste and Abuse ("FWA") or other Compliance issues. Suspected FWA and/or Compliance issues must be reported to DentaQuest in a timely manner. Failure to report Compliance issues, or comply with Compliance and FWA policies, standards and requirements could lead to removal from the network, legal action or recovery of payments. Providers must publicize these disciplinary standards to their employees and downstream entities.

### Compliance/Ethics

DentaQuest takes compliance with all applicable federal and state laws and the prevention of fraud, waste, and abuse and resolution of compliance issues very seriously. DentaQuest policy emphasizes the common values for actions and establishes resources to help resolve questions about compliance issues. Please review this section thoroughly. The need for each provider's adherence to its spirit and specific provisions cannot be overemphasized. All providers and their employees and agents have important responsibilities, including a duty to report compliance concerns.

Providers or their staff members who have questions regarding anything found in this section or who encounter a situation they believe violates its provisions should notify DentaQuest immediately. This section provides ways to express a compliance concern and it can be done anonymously. Be assured, there will be no retribution for asking questions or raising compliance concerns.

Providers should take great care to ensure all claims submitted to DentaQuest reflect accurate information and conform to applicable federal and state laws and regulations. No provider or their employee or agent should knowingly present, or cause to be presented, claims to DentaQuest for payment or approval that are false, fictitious, or fraudulent.

DentaQuest reserves the right to conduct periodic audits and monitoring of a provider to confirm that compliance goals are being maintained and assist in the reduction of any identified problem areas. Auditing and monitoring activity will include periodic profiling to identify any changes in billing patterns that may indicate improper activities.

Providers should periodically conduct educational programs for their staff to assure continued compliance with all applicable laws. It is imperative that providers require their professional staff and all other employees to attend compliance education programs and they agree to abide by all applicable codes of conduct adopted by the provider. A similar education requirement should be made of all independent contractors and agents providing healthcare-related services to the provider.

### **Conflicts of Interest**

All providers, their employees and downstream entities must avoid conflicts of interest. Providers should never offer or provide anything of value, including but not limited to, cash, bribes, or kickbacks to any DentaQuest associate, representative or patient or government official in connection with any DentaQuest procurement, transaction or business dealing. This prohibition also applies to any family members or significant others.

Providers must obtain conflicts of interest statements from all employees and Downstream Entities within 90 days of hire or contract and annually thereafter. This statement must certify that the employees or downstream entities are free from any conflict of interest that would prevent them from administering or delivering federal healthcare benefits or services. All providers must review potential conflicts of interest and either remove the conflict or, if appropriate, obtain approval from affected parties to continue work despite the conflict.

DentaQuest reserves the right to obtain certification from all providers and require that certification conflicts be removed, or that the applicable individuals or entities be removed, from supporting DentaQuest.

Providers are prohibited from having any financial relationship relating to the delivery of or billing for covered services that:

- Violate the federal Stark Law, 42 U.S.C. § 1395nn, if healthcare services delivered in connection with the relationship were billed to a federal healthcare program or would violate comparable state laws
- Violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if healthcare services delivered in connection with the relationship were billed to a federal healthcare program or would violate comparable state laws
- In the judgment of DentaQuest, could reasonably be expected to influence a provider to utilize or bill for covered services in such a way that is inconsistent with professional standards or norms in the local community.

**Providers are subject to termination by DentaQuest for violating this prohibition.** DentaQuest reserves the right to request such information and data, as it may be required to certify ongoing compliance with these provisions.

### **Expression of Compliance Concerns**

The cornerstone of this manual is the expectation that all providers and support staff members feel free to report compliance concerns to DentaQuest or applicable regulatory authorities without fear of reprisal or disciplinary action. Providers and their staff are expected to report any compliance concerns they may have, including activity by another employee, physician or contractor that appears to violate applicable laws, rules, regulations, or this manual.

Providers are also encouraged to submit suggestions on ways to improve DentaQuest's compliance program. DentaQuest will not take, nor allow reprisals or disciplinary action against anyone solely because they express a compliance concern.

### **How Providers Should Express a Concern**

There are several alternatives for reporting compliance concerns. They include DentaQuest's toll-free hotlines and other mechanisms that should be equally effective and allow providers to report a concern anonymously. Please refer to page 4 of this manual for the different ways to report compliance concerns and FWA.

While formal submission of a compliance concern report is the preferred method of expressing a concern or complaint, a written explanation or verbal report (even one made anonymously over the telephone) is acceptable. Upon receipt, a reported compliance concern will be documented by the DentaQuest Compliance Department and will include a summary and a preliminary analysis of the issue.

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In the event the compliance concern is determined to present a significant issue with respect to compliance, a special meeting of the Compliance Committee will be held.

**Anonymity**

DentaQuest will strive to keep the reporting provider or staff member's identity confidential but, despite its best efforts, there may be instances where the individual's identity will become known or may have to be revealed. An assertion of FWA or a compliance violation by an employee who may have participated in the activities being reported raises numerous complex legal and management issues that must be examined on a case-by-case basis. DentaQuest personnel will be admonished to work closely with legal counsel to ensure that the rights of the reporting person, as well as those of the provider organization, are protected during the investigation and ultimate resolution of such issues.

**Violations and Investigations**

Failure to comply with applicable federal or state laws, rules, regulations, and program instructions threatens DentaQuest and its affiliates' status as reliable, honest, and trustworthy organizations.

Detected, but uncorrected, misconduct can seriously endanger the mission, reputation, and legal status of this organization. Consequently, upon receiving a report or becoming aware of suspected non-compliance, the DentaQuest Compliance Department and the Compliance Officer will promptly investigate the conduct in question. If a violation has occurred, steps will be taken to correct the problem. They may include a referral to criminal and/or civil law enforcement authorities, a report to the government and/or a corrective action plan.

**Disciplinary Actions for Failure to Follow Compliance Policies**

An effective compliance program depends upon providers and their staffs fulfilling their duties and responsibilities. Providers, managers, supervisors, and support staff will be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable compliance standards, laws, and procedures, which include following reporting requirements and assisting with the resolution of compliance issues or concerns, that are within the scope of their job duties and responsibilities.

## Healthy Kids Dental Program

The Michigan Department of Health and Human Services has selected Blue Cross Blue Shield of Michigan as one of two organizations to administer the statewide Healthy Kids Dental (HKD) program beginning October 1, 2018. Blue Cross selected DentaQuest as its network vendor. The HKD program covers nearly one million Medicaid-eligible children in Michigan.

The Healthy Kids Dental (HKD) program provides dental coverage for children who have Medicaid and are under the age of 21. There are no copays or deductibles.

### Contract Goals

The HKD program is a key component of Michigan’s comprehensive oral health plan. Specific goals include:

1. Leveraging the HKD model to promote good oral health practices among the HKD population that result in:
  - increased utilization of preventive Dental Services
  - increased oral health education that emphasizes the importance of good oral health and practices
  - decreased dental anxiety
2. Promoting a patient-centered approach that recognizes the importance of dental care in overall health care and promoting professional integration and coordination of care across provider types.
3. Increasing the number of dental providers participating in the HKD program.
4. Increasing access to oral health care.
5. Designing and implementing best practices for Dental Service delivery in dental care health shortage areas with limited dental providers.
6. Collaborating with community organizations and stakeholders resulting in partnerships that leverage existing dental programs (i.e. school based, dental clinics etc.).
7. Increasing education and Dental Service usage among Enrollees who are pregnant and Children with Special Needs.

The Healthy Kids Dental program offers more comprehensive dental coverage with some limitations. The program generally covers:

Emergency dental services	Endodontic Services
Diagnostic services	Limited crown coverage
Preventive services	Prosthodontics
Sealants	Removable Prosthodontics
Restorative Services	Oral Surgery Services
Limited Adjunctive Services	Additional Medically necessary services

### **A full list of covered codes can be viewed in Exhibit A Healthy Kids Covered Benefits**

Please refer to the **MDHHS Medicaid Provider Manual -Dental Chapter** for Medicaid policies, covered dental services, coverage parameters, services that require prior authorization, billing instructions, etc. You may click on this link to access this manual <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf> or visit [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs) and select it under Online Services located at the bottom of the landing page.

## Office Reference Manual

**Purpose:** a resource tool designed to provide information to network participating providers including but not limited to:

- a) DentaQuest policies and procedures, grievances, appeals, and fair hearing procedures and timeframes, claims filing, benefits and limitations, prior authorizations, orthodontic criteria, EPSDT services, and other topics including pertinent addresses and telephone numbers for additional assistance, as applicable and/or required by client, product, or Health Plan.
- b) The ORM is made available to prospective practitioners during recruitment efforts and at the time of contracting by providing a link to the most up to date version of the ORM online
- c) The ORM assists practitioners in running an efficient office and keeps offices informed of changes that may occur from time to time.
- d) Material changes to the content of the ORM are communicated to participating network providers by the Provider Engagement team as necessary or required by statutory, regulatory, or contractual obligations.
- e) The ORM is updated on an annual basis or periodically throughout the year based on updates where applicable.
- f) The ORM is accessible to DentaQuest Customer Service Representatives and other appropriate staff to serve as a tool and assist with network provider questions as needed.

## Provider Engagement Representatives

DentaQuest has found that personalized service is critical to assist provider offices with more specialized network or plan questions and escalated issues. Thus, our Provider Engagement representatives are available during normal business hours and will respond to voicemails, e-mails, and mail within one business day. To find out who is the assigned territory Provider Engagement representative for your office location, call Provider Services at 844.876.7917.

**Office Reference Manual  
Table of Contents**

<b>Section</b>	<b>Page</b>
<b>Contents</b>	
DentaQuest, LLC .....	2
Address and Telephone Numbers .....	2
CHAMPS: Medicaid Enrollment Requirement:.....	3
Cultural Competency Training Requirement .....	3
Fraud, Waste/Error and Abuse and General Compliance Training Requirement .....	4
Healthy Kids Dental Appointment and Timely Access to Care Standards.....	4
Statement of Members Rights and Responsibilities .....	5
Statement of Provider Rights and Responsibilities .....	7
Member Confidentiality and Release of Information.....	9
Compliance Language .....	11
Healthy Kids Dental Program .....	14
Office Reference Manual.....	16
Table of Contents .....	16
<b>1.00 Patient Eligibility Verification Procedures .....</b>	<b>22</b>
1.01 Plan Eligibility.....	22
1.02 Member Identification Card .....	22
1.03 DentaQuest Eligibility Systems.....	22
Access to eligibility information via the IVR line .....	23
1.04 State Eligibility System .....	24
1.05 Specialist Referral Process .....	24
<b>2.00 Emergency Services .....</b>	<b>24</b>
<b>3.0 Authorization for Treatment .....</b>	<b>24</b>
3.01 Dental Treatment Requiring Authorization .....	25
3.02 Payment for Non-Covered Services .....	26
3.03 Electronic Attachments .....	26
3.04 Dispute Resolution /Provider Appeals Procedure.....	27
<b>4.00 Participating Hospitals.....</b>	<b>28</b>



---

<b>5.00</b>	<b>Claim Submission Procedures (claim filing options)</b> .....	<b>28</b>
5.01	Submitting Authorization or Claims with X-Rays .....	29
5.02	Electronic Claim Submission Utilizing DentaQuest’s Internet Website .....	29
5.03	Electronic Authorization Submission Utilizing DentaQuest’s Internet Website .....	30
5.04	Electronic Claim Submission via Clearinghouse .....	30
5.05	HIPAA Compliant 837D File .....	30
5.06	NPI Requirements for Submission of Electronic Claims .....	30
5.07	Paper Claim Submission .....	31
5.08	Coordination of Benefits (COB) .....	32
5.09	Filing Limits .....	32
5.10	Receipt and Audit of Claims.....	32
5.11	Direct Deposit.....	32
<b>6.00</b>	<b>Health Insurance Portability and Accountability Act (HIPAA)</b> .....	<b>33</b>
6.01	Use of Provider Information .....	34
6.02	HIPAA Companion Guide .....	34
<b>7.00</b>	<b>Inquiries, Appeals and Grievances</b> .....	<b>35</b>
<b>8.00</b>	<b>Utilization Management Program</b> .....	<b>37</b>
8.01	Introduction .....	37
8.02	Community Practice Patterns .....	37
8.03	Evaluation .....	38
8.04	Results .....	38
8.05	Fraud, Prevention and Recovery .....	38
	<b>False Claims Act</b> .....	<b>40</b>
	Federal False Claims Act (FCA) .....	40
	State False Claims Acts .....	40
	Whistleblower Protection.....	40
<b>9.00</b>	<b>Quality Improvement Program</b> .....	<b>40</b>
<b>10.00</b>	<b>Credentialing Policies</b> .....	<b>41</b>
<b>11.00</b>	<b>The Patient Record</b> .....	<b>41</b>

---

A.	Organization .....	42
B.	Content-The patient record must contain the following: .....	42
C.	Compliance .....	45
12.00	Patient Recall System Requirements .....	45
A.	Recall System Requirement .....	45
B.	Office Compliance Verification Procedures .....	45
13.00	Radiology Requirements .....	46
A.	Radiographic Examination of the New Patient .....	46
B.	Radiographic Examination of the Recall Patient .....	46
14.00	Clinical Criteria .....	48
14.01	Criteria for Dental Extractions.....	49
	Documentation needed for authorization procedure: .....	49
	Criteria 49	
14.02	Criteria for Cast Crowns .....	50
	Documentation needed for authorization of procedure: .....	50
	Criteria 50	
	A request for a crown following root canal therapy must meet the following criteria: .....	50
	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. ....	50
	Authorizations for Crowns will not meet criteria if:.....	51
14.03	Criteria for Stainless Steel Crowns.....	51
	Documentation needed for authorization of procedure: .....	51
	Criteria 51	
	An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:.....	51
	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. ....	52
	Authorization and treatment using Stainless Steel Crowns will not meet criteria if: .....	52
14.04	Criteria for Authorization of Operating Room (OR) Cases .....	52
	Documentation needed for authorization of procedure: .....	52
	Criteria 52	
14.05	Criteria for Removable Prosthodontics (Full and Partial Dentures) .....	53
	Documentation needed for authorization of procedure: .....	53
	Criteria 53	
	Authorizations for Removable prosthesis will not meet criteria: .....	54

---

<b>Criteria 54</b>	
14.06 Criteria for the Excision of Bone Tissue .....	55
Documentation needed for authorization of procedure: .....	55
14.07 Criteria for the Determination of a Non-Restorable Tooth .....	55
14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation .....	55
Documentation needed for authorization of procedure: .....	56
<b>Criteria 56</b>	
Extensive or complex oral surgical procedures such as: .....	56
And/or one of the following medical conditions:.....	56
15.00 Loss or Change in Eligibility .....	56
<b>APPENDIX A</b> .....	58
Attachments.....	58
General Definitions .....	58
Additional Resources.....	59
<b>RECALL EXAMINATION</b> .....	63
<b>RECALL EXAMINATION</b> .....	63
<b>Authorization for Dental Treatment</b> .....	64
AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS .....	65
DISBURSED BY DENTAQUEST, LLC.....	65
<b>INSTRUCTIONS</b> .....	65
<b>MAINTENANCE TYPE:</b> .....	65
<b>ACCOUNT HOLDER INFORMATION:</b> .....	65
<b>MEDICAL AND DENTAL HISTORY</b> .....	66
<b>Request for Transfer of Records</b> .....	68
<b>Agreement to Pay Non-Covered Services</b> .....	69
<b>837 Dental Companion Guide</b> .....	70
<b>1.0 Introduction</b> .....	71
Section 1.1 <i>What Is HIPAA?</i> .....	71
Section 1.2 <i>Purpose of the Implementation Guide</i> .....	71
Section 1.3 <i>How to Obtain Copies of the Implementation Guides</i> .....	71
Section 1.4 <i>Purpose of this Companion Guide</i> .....	71
Section 1.5 <i>Intended Audience</i> .....	72

---

Section 1.6	<i>Introduction to the 837 Dental Healthcare Claims Transaction</i> .....	72
2.0	<b>Trading Partners</b> .....	72
Section 2.1	<i>General Overview</i> .....	72
Section 2.2	<i>Establishing Connectivity</i> .....	73
Section 2.3	<i>Trading Partner Testing</i> .....	73
3.0	<b>Technical Requirements</b> .....	74
Section 3.1	<i>File Size</i> .....	74
Section 3.2	<i>Naming Convention</i> .....	74
Section 3.3	<i>Multiple Transactions Types In a File</i> .....	74
Section 3.4	<i>Balancing Data Elements</i> .....	74
4.0	<b>Acknowledgments</b> .....	74
Section 4.1	<i>Functional Acknowledgment Transaction Set (997)</i> .....	74
5.0	<b>Support Contact Information</b> .....	74
6.0	<b>Specific Data Requirements</b> .....	75
Section 6.1	<i>Claim Attachments</i> .....	75
Section 6.2	<i>Predeterminations</i> .....	75
Section 6.3	<i>Coordination of Benefits (COB) Claims</i> .....	75
Section 6.4	<i>Void Transactions</i> .....	75
Section 6.5	<i>Detail Data</i> .....	76
6.5.01	<b>Control Segments</b> .....	76
6.5.02	<b>ISA – Interchange Control Header segment</b> .....	76
6.5.03	<b>IEA – Interchange Control Trailer</b> .....	76
6.5.04	<b>GS-Functional Group Header</b> .....	77
6.5.05	<b>GE-Functional Group Trailer</b> .....	77
6.5.06	<b>Preferred Delimiters</b> .....	77
6.5.07	<b>Segment Definitions</b> .....	77
6.5.08	<b>837 Dental Healthcare Claim Transaction</b> .....	78
7.0	<b>APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES</b> .....	82
	<b>APPENDIX B</b> .....	84
	<b>IMPORTANT</b> .....	85
	<b>No Prior Authorization Required/Advisory</b> .....	85

---

**Members will not be notified if the prior authorization request was deemed 'advisory'. They will receive a notice of approval or denial decisions. ....85**

**PLEASE NOTE .....85**

**1.00 Patient Eligibility Verification Procedures**

**1.01 Plan Eligibility**

Any person who is enrolled in this program is eligible for benefits under the Plan’s Coverage of Certificate.

**1.02 Member Identification Card**

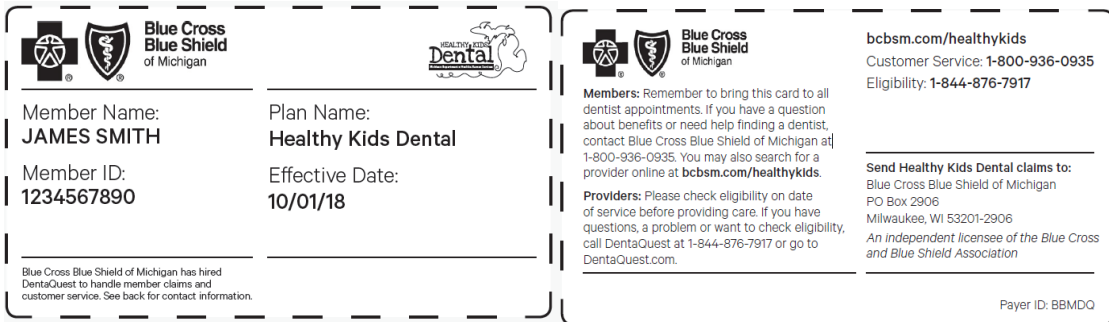
Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

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

Members will receive a Plan ID Card.

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

**Sample of Blue Cross Blue Shield of Michigan-Healthy Kids Dental I.D. Card:**



**1.03 DentaQuest Eligibility Systems**

Participating Dental Providers may access Member eligibility information through DentaQuest’s Interactive Voice Response (IVR) system or via the BCBSM Provider Portal.

To access the BCBSM Provider Portal, **First Time Users** must **register** at: <http://provideraccess.dentaquest.com>

**After registering**, there are two ways to login/access the BCBSM Provider Portal:

1. via the “Providers Only” section of DentaQuest’s website at [www.dentaquest.com](http://www.dentaquest.com), select “Dentists” > Michigan > Dentist Portal Login > BCBSM Login, or
2. via the URL: <http://provideraccess.dentaquest.com> enter User ID/Password

The eligibility information received from either system will be the same information you would receive by calling DentaQuest’s Provider Services; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Service Representative.

**Providers must verify eligibility prior to rendering services.** Verification of eligibility on the date of service of each BCBSM HKD member is essential as eligibility for these members may change frequently. If you do not check eligibility on the date of service for a BCBSM HKD member before you begin treatment, and deliver services to an ineligible member, you cannot receive reimbursement from BCBSM and cannot bill the member for the services. If you have not already done so, please set up a process where you check BCBSM HKD member eligibility on their appointment days.

#### **Access to eligibility information via the Internet**

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial.

To access the eligibility information be sure to register as a First Time User at: <http://provideraccess.dentaquest.com> . To register, you will need to utilize the Business's NPI or TIN, State and Zip Code. If you need instruction on how to complete Provider Self Registration, contact DentaQuest's Provider Service Department at 844-876-7917.

**After initial registration**, log on to Blue Cross Blue Shield of Michigan Medicaid portal <http://provideraccess.dentaquest.com> , OR via DentaQuest's website, at [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the DentaQuest website, **select "Dentists" > Michigan > Dentist Portal Login>BCBSM Login**. Once logged in, select "Member eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

#### **Access to eligibility information via the IVR line**

To access the IVR, simply call DentaQuest's Provider Services at 844-876-7917, then press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Provider Services Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid Member by entering your 6 digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Provider Services Representative.

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

If you are having difficulty accessing either the IVR or website, please contact the Provider Services at 844-876-7917. They will be able to assist you in utilizing either system.

#### **Directions for using Doral's IVR to verify eligibility:**

**Entering system with Tax and Location ID's**

1. Call Doral Customer Service at 800.341.8478.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number. .
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

#### **1.04 State Eligibility System**

##### **A. MDHHS Eligibility Request Transactions 270/271**

The 270 Eligibility Request transaction is a query that Trading Partners may use to obtain coverage, eligibility, and benefit information. Upon receipt of a 270 Eligibility Request, The Michigan Department of Health and Human Services (MDHHS) will return the 271 (benefit coverage) Response transaction to the Trading Partner.

For more information on this process visit:

<http://www.michigan.gov/tradingpartners>

##### **B. Michigan ENROLLS (members only)**

1-800-975-7630

TTY: 1-888-263-5897

8 a.m. - 7 p.m. EST, Monday-Friday

#### **1.05 Specialist Referral Process**

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for reviewing and providing services in accordance with Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Provider Services Department.

#### **2.00 Emergency Services**

- A. Participating providers are required to ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have an after hours number.
- B. Emergency dental providers offering dental emergency services are required to perform a dental exam leading to a clinical determination that an emergency dental condition does exist. The provider must provide whatever treatment is necessary to treat the condition.

#### **3.0 Authorization for Treatment**



### 3.01 Dental Treatment Requiring Authorization

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

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

**A.** Authorization and documentation submitted before treatment begins (Non-emergency) treatment.

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

Your submission of “documentation” should include:

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

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

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

**B.** Submitting Authorization Requests and X-Rays

- Electronic submission using the BCBSM-Medicaid web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit [www.nea-fast.com](http://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 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

\*Benefit determination on standard authorizations will be completed within 14 calendar days.

**C. Authorization and documentation submitted with claim (Emergency treatment)**

DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations, services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

\*Benefit determination on Emergency (or expedited) authorizations will be completed within 72 hours.

**3.02 Payment for Non-Covered Services**

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

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

**3.03 Electronic Attachments**

DentaQuest accepts dental radiographs electronically via FastAttach™ for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those

that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to [www.nea-fast.com](http://www.nea-fast.com) or call NEA at:

800.782.5150

### **3.04 Dispute Resolution /Provider Appeals Procedure**

Participating Providers that disagree with post service determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This notice *and* additional support information must be sent to DentaQuest within **180** days from the date of the original determination.

DentaQuest, LLC  
Attn: BCBSM Provider Appeal  
P.O. Box 491  
Milwaukee, WI 53201-0491

or call to file an appeal:

Dental Customer Service: 1-844-876-7917 (TTY: 711)  
Fax: 262-834-3452

DentaQuest will respond in writing with its decision to the Provider no later than 30 calendar days after the receipt of the request and any necessary supporting documentation.

DentaQuest will cooperate with Participating Providers seeking resolution after exhausting the appeals process by entering into arbitration or other alternative dispute resolution process.

1. Members, Providers, or Member Representatives are eligible to request an External Appeal if they receive a Final Adverse Determination letter for one of the conditions below. The Independent Review Entity (IRE) does not have any direct financial interest in the organization or in the outcome of the independent review.
2. Service is clinical in nature and the internal appeal decision is adverse to the member.
3. DQ does not require the member/provider to complete the external appeal before requesting a State Fair Hearing (SFH).
4. The external appeal is completed by an entity independent of DQ, the health plan and state Medicaid agency. The external review agent was not involved in the original determination under appeal.
5. The external appeal is offered without any cost to the enrollee or provider.
6. The external appeal does not extend the timeframes specified for the internal appeal and does not disrupt the continuation of benefits.

### **Payment Resolution Dispute Process**

For Michigan providers that have exhausted every level of payment determination appeal with DentaQuest, providers have the option to seek the Alternative Dispute Resolution Process set forth below (“ADR Process”). Please note that any determination following an appeal to an Independent Review Board, Utilization Review Organization or Medicaid Fair Hearing is conclusive upon the parties and not subject to further appeal unless otherwise provided for under federal or state law. The ADR Process does not include disputes related to medical necessity.

A provider may file an ADR Process request in writing with the DentaQuest provider relations team to resolve billing, payment and other administrative disputes, including but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other billing related reason.

ADR Process requests must be filed on or before the 30th calendar day following DentaQuest’s determination which forms the basis of the dispute. The provider may be requested to complete and submit an ADR Process form together with any appropriate supporting documentation. If the additional information does not resolve the dispute, the provider may request non-binding mediation in which case DentaQuest will submit the dispute to the American Health Law Association Dispute Resolution Services (“AHLADRS”). The parties will mutually agree upon a single, neutral AHLADRS mediator and each party will bear its own fees and costs related to the mediation. The mediator does not have the authority to award attorneys’ fees or other dispute costs to the prevailing party.

**Participating Providers that disagree with pre-service should refer to section 7.00 Inquiries, Appeals and Grievances.**

### **Provider Grievances**

DentaQuest must receive **Provider grievances** in writing. All documentation relating to the grievance should be included in the submission.

All **Provider grievances** should be sent to:

DentaQuest, LLC  
Attn: Provider Grievance  
P.O. Box 491  
Milwaukee, WI 53201-0491

Provider Services: 844.876.7917

DentaQuest will respond to provider grievances no later than 30 calendar days.

**Note:** Copies of DentaQuest policies and procedures can be requested by contacting Provider Services at 844-876-7917.

### **4.00 Participating Hospitals**

Upon approval, Participating Providers are required to administer services at Plan’s participating hospitals. Please contact your Health Plan for further information.

### **5.00 Claim Submission Procedures (claim filing options)**

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

- Electronic claims via DentaQuest's Provider Portal (log on the Blue Cross Blue Shield of Michigan Medicaid portal) at <http://provideraccess.dentaquest.com> or via [www.dentaquest.com](http://www.dentaquest.com).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

### 5.01 Submitting Authorization or Claims with X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit [www.nea-fast.com](http://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 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

### 5.02 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 the Blue Cross Blue Shield of Michigan Medicaid portal at <http://provideraccess.dentaquest.com>, or you may also access the portal via [www.dentaquest.com](http://www.dentaquest.com). Once you have entered website, click on the "Dentists" icon.

From there choose Michigan as your "State" and click on Dentist Portal Login > BCBSM Login and enter User ID and password. **First time users** will have to register by utilizing

the Business's NPI or TIN, State and Zip Code.

Once logged in, select "Claims/Pre-Service" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on provider registration, submitting claims or accessing the website, please contact our Provider Services Department at 844-876-7917 for assistance.

### **5.03 Electronic Authorization Submission Utilizing DentaQuest's Internet Website**

Participating Providers may submit Pre-Estimates (preauthorization) directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Pre-Estimates 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-estimates via the website, simply log on to DentaQuest's Provider Portal for Blue Cross Blue Shield of Michigan Medicaid: <http://provideraccess.dentaquest.com> or you may also access the portal via [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the DentaQuest website, click on the "Dentists" icon. From there choose Michigan as your "State" and click on the Dentist Portal Login > BCBSM Login and enter User ID and password. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Should you require assistance for Provider Self Registration, please contact DentaQuest's Provider Services Department at 844.876.7917. Once logged in, select "Claims/Pre-Estimates" and then "Dental Pre-Estimate Entry."

The DentaQuest's Provider Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-estimates.

### **5.04 Electronic Claim Submission via Clearinghouse**

DentaQuest works directly with Change Healthcare (Emdeon) (888-255-7293), InMediata (877-466-9656), Claim Remedi (800-763-8484), DentalXChange (877-932-2567) and Tesia (866-432-1917) 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 BBMDQ.**

### **5.05 HIPAA Compliant 837D File**

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email [EDITEAM@greatdentalplans.com](mailto:EDITEAM@greatdentalplans.com) to inquire about this option for electronic claim submission.

### **5.06 NPI Requirements for Submission of Electronic Claims**

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website [https://nppes.cms.hhs.gov/assets/How\\_to\\_apply\\_for\\_an\\_NPI\\_online.pdf](https://nppes.cms.hhs.gov/assets/How_to_apply_for_an_NPI_online.pdf) and provide this

information to DentaQuest in its entirety.

- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

#### **5.07 Paper Claim Submission**

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

Blue Cross Blue Shield of Michigan  
Attn: Claims

P.O. Box 491  
Milwaukee, WI 53201-0491

### **5.08 Coordination of Benefits (COB)**

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

### **5.09 Filing Limits**

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

### **5.10 Receipt and Audit of Claims**

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

Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

#### Overpayment of Claims

A provider who receives an overpayment must self-identify and report the overpayment to DentaQuest immediately upon identification of having received an overpayment. a. Providers initiating refund may send check with a letter, EOP, and their own form. b. Upon receipt, DentaQuest will review the unsolicited refund to determine if the overpayment is related to activities of fraud, waste/error, and abuse vs. administrative reasons. c. Administrative refunds would not trigger a notification. d. Administrative refund examples: i. Provider sends check for procedure not done, ii. Wrong code used, wrong code submitted and will submit correct. e. DentaQuest will review the applicable Michigan Medicaid State and Federal databases and watch lists to determine if the provider submitting the overpayment refund is under active federal or Michigan Medicaid state investigation or prosecution. f. DentaQuest may cash any payments received from the provider within five (5) business days of receiving a complete provider-initiated refund but must still complete a review of the overpayment to ascertain the possible existence of any fraud.

### **5.11 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 that can be found on DentaQuest's Provider Portal (log on the Blue Cross Blue Shield of Michigan Medicaid portal <http://provideraccess.dentaquest.com>) or you may also access the portal via [www.dentaquest.com](http://www.dentaquest.com).
- 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 Email – [standardupdates@dentaquest.com](mailto:standardupdates@dentaquest.com)
  - Via Mail – DentaQuest, LLC  
P.O. Box 2906  
Milwaukee, WI 53201-2906  
ATTN: PEC Department

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

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

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

1. Go to DentaQuest's Provider Portal (log onto the Blue Cross Blue Shield of Michigan Medicaid portal <http://provideraccess.dentaquest.com> or you may also access the portal via [www.dentaquest.com](http://www.dentaquest.com)).
2. Once you have entered the website, click on the "Dentists" icon. From there choose Michigan as your "State" and click on Dentist Portal Login> BCBSM Login and enter User ID and password.
3. Once logged in, select "Claims/Pre-Estimates," select Explanation of Benefits, and select EFT Trace Number.
4. The remittance will display on the screen

## 6.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates

include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and Michigan Medicaid state law and per the Medicaid Provider Manual.
- Safeguarding of all information about Members according to applicable Michigan Medicaid state and federal laws and regulations and per the Medicaid Provider Manual. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

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

### **6.01 Use of Provider Information**

As a Participating Provider or a Participating Practice, you authorize DentaQuest, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this dental ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose Participating Practice's and Participating Provider's information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose such personal information to third parties, we require them to protect the privacy and security of this information.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Services Department at 844-876-7917 or via e-mail at [denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com).

### **6.02 HIPAA Companion Guide**

To view a copy of the most recent Companion Guide please visit our website at [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose Michigan as your "State" and click on the BCBSM Login and enter User ID and password. Once you have logged in, click on the link named "Related

Documents' (located under the picture on the right-hand side of the screen).

## 7.00 Inquiries, Appeals and Grievances

The member is encouraged to discuss his/her concerns with those directly involved such as the provider, medical assistant, receptionist, office or administrative manager. If the question or concern is unresolved, the member is instructed to call or write to the plan.

DentaQuest in conjunction with the plan has established a member grievance process that guarantees any member the right for a review when they are dissatisfied with a service/benefit. The member is informed that they may request a State Fair Hearing for appeals, which can only be filed after the member has filed an appeal and been notified that we upheld the adverse benefit determination. Members will receive assistance, if required, to file either a grievance or an appeal. Members may file grievances and appeals orally or in writing.

Members have two distinct processes to indicate dissatisfaction. These processes are a member appeal or a member grievance. Within the appeal process there is an opportunity for a member to request an expedited appeal as noted below. The grievance process does not have an expedited timeframe period. For both levels, the members have the right to submit written comments.

Members also have the right to request and receive a written copy of DentaQuest's utilization management criteria in cases where the appeal is related to a clinical decision/denial or other applicable plan policies or procedures relevant to the decision or action that is the subject of the appeal. Members are instructed to call or write to the plan to request this information.

DentaQuest adheres to Michigan Medicaid State, Federal, Medicaid Provider Manual and plan requirements related to processing inquiries, grievances and appeals. Members have the right to request continuation of benefits while utilizing the grievance system, but if the action is upheld the member may be liable for the cost of continued benefits. Unless otherwise required by Agency and Plan, DentaQuest's processes such as inquires, grievances and appeals consistent with the following:

**Inquiry:** Any member's request for administrative service, information or to express an opinion.

**Grievance:** Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or authorized representative may make the complaint or dispute, either orally or in writing, to a plan, provider or facility. A determination will be made on grievances within 60 days of the submission.

**Member grievances** should be sent to:

Blue Cross Blue Shield of Michigan  
Attn: Grievance and Appeals Unit  
P.O. Box 491  
Milwaukee, WI 53201-0491

Or call to file a grievance:

Dental Customer Service: 1-800-936-0935 (TTY: 711)  
Fax: 262-834-3452

**Appeal:** A request for review of a decision that results in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service

- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a properly authorized and covered service
- The failure to provide services in a timely manner, as defined by the State
- The failure of an Entity to act within the established timeframes for grievance and appeal disposition

**Pre-Service Non-Expedited Appeals:** The member or provider may file a non-expedited appeal orally or in writing within 60 days from the date of the adverse benefit determination. A determination on non-expedited appeals will be made within 30 calendar days from the receipt of the request.

**Pre-Service Expedited Appeals:** When a service has been delayed, denied, reduced or terminated, the member or their authorized representative can request verbally or in writing a request for review and reconsideration of an action in an urgent or expedited timeframe, if he/she feels the normal timeframe of the appeal procedure would seriously jeopardize their life or dental health or ability to attain, maintain, or regain maximum function. An expedited appeal cannot be requested when the service(s) has already been rendered. Provider requests for an expedited appeal are considered member appeals and subject to member appeal timeframes and policies.

The member or provider may file an expedited appeal either orally or in writing. A request for an expedited appeal must be made within 10 days of the adverse determination. Requests for an expedited review that meet the above criteria will have the determinations made within seventy-two (72) hours.

All **member appeals** should be sent to:

Blue Cross Blue Shield of Michigan  
Attn: Grievance and Appeals Unit  
P.O. Box 491  
Milwaukee, WI 53201-0491

or call to file an appeal:

Dental Customer Service: 1-800-936-0935 (TTY: 711)  
Fax: 262-834-3452

### **Peer to Peer Request**

DentaQuest providers may contact Provider Services by telephone, 844.876.7917 or Fax: 262-834-3452 to schedule a peer to peer call to discuss coverage determinations with a DentaQuest Dental Consultant. A Peer to Peer Request has up to 180 calendar days from the date of determination to be requested.

Provider contacts provider services and requests a peer to peer call with a Dental Consultant regarding initial determination.

Peer to Peer requests are to discuss clinically denied cases with a Dental Consultant. Administrative (non-clinical) denials are not eligible for Peer to Peer.

Clinical denials will not be overturned through the Peer to Peer process. The provider will be advised to resubmit through prior-authorization, claim or appeal.

1. The DentaQuest Dental Consultant makes first call attempt, but the provider is not available.

- a. Dental Consultant will leave a message that another call attempt will be initiated on the next business day.
  - b. Dental Consultant makes second attempt to reach provider office. If the provider is still unavailable, Dental Consultant enters comments into follow-up and resolves peer to peer request.
2. The Dental Consultant speaks with the provider.
  - a. Dental Consultant will speak to Provider and discuss case regarding alleged determination error or questions with respect to clinical criteria.
  - b. If the Provider has additional information that would change the status of the determination, Dental Consultant will advise Provider to file an appeal.
  - c. Dental Consultant enters comments into follow-up and resolves peer to peer request.

### **State Medicaid Appeals Process**

If a Member does not agree with plan's decision on a benefit determination, he/she may choose from the following two appeal processes:

- (1) State Fair Hearing: A member, a member's representative, or a provider may request a Medicaid State Fair Hearing. The request must be filed within 120 days after notification of the internal appeal decision. Copies of the Request for State Fair Hearing form can be obtained by calling Blue Cross Blue Shield of Michigan at 800-936-0935
- (2) External Review: Members may also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Department of Insurance and Financial Services (DIFS). A Health Care Request for External Review form must be filled out, and sent with all supporting documentation, to the address or fax number listed on the form. A copy of the form is available by calling DIFS at 1-877-999-6442. The request must be sent within 60 calendar days of notification of the internal appeal decision.

## **8.00 Utilization Management Program**

### **8.01 Introduction**

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, Michigan Medicaid 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.

### **8.02 Community Practice Patterns**

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

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists

and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

### 8.03 Evaluation

DentaQuest's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

### 8.04 Results

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.

### 8.05 Fraud, Prevention and Recovery

DentaQuest is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud, waste/error, and abuse in dentistry occurs when a provider/office or a member knowingly submits or helps someone else submit false information on a dental claim form.

Fraud, Waste/Error, and Abuse is defined as:

- **Fraud:** includes any instances of waste/error or abuse if committed with intentional deception or misrepresentation.
- **Waste/Error:** includes over-utilization of services or practices that result in unnecessary costs to the healthcare system.
- **Abuse:** provider practices are inconsistent with sound fiscal business resulting in unnecessary costs or reimbursement for services that are not dentally necessary, fail to meet professionally recognized standards of care, involve non-compliance with licensure standards, misuse of billing privileges, or any other behavior that results in unnecessary costs to the healthcare system.

As a result of a complaint or through comprehensive data analysis DentaQuest's Fraud Prevention and Recovery Unit undertakes reviews of potential aberrant utilization and billing patterns; and may conduct a record reviews of a dental provider/offices to assess any potential fraud, waste/error, or abuse. Similarly, it reviews post payment records to evaluate the dental necessity of the procedures performed and billed, as well as the administrative requirements that support the procedure billed for payment.

While fraud, waste/error, and abuse can take many forms, the following issues and trends have been identified by DentaQuest's Fraud Prevention and Recovery Investigators during chart audits:

#### FRAUD

- Filing a claim for a service not provided
- Falsifying information on a claim form in attempt to gain benefits
  - Procedure performed

- Treating dentist
- Tooth, quadrant, surface treated
- Date of service
- Location of service
- Altering a claim, diagnosis and/or other records
  - Resubmitting a claim with a modified/altered date of service to maximize benefits and/or circumvent a time limitation
- Billing non-covered services as covered services
  - Billing for a four or more surface anterior composite restoration when documentation supports an indirect composite veneer was performed
- Using someone else's identification card

#### ABUSE

- Upcoding - billing for a more costly service than was actually performed
  - Billing for a completely bony extraction when documentation indicates a partially bony extraction was performed
- Billing for a composite restoration when documentation indicates that a preventative restoration was performed.
- Unbundling - billing each stage of a procedure separately
  - Billing each tooth surface involved in a restoration as a separate line item
- Billing for oral evaluations without documentation to support the services were rendered by a licensed dentist
- Absence of dental necessity
  - Direct or Indirect restorations performed without evidence of decay or fractured tooth structure
- Billing for services using the identification of a contracted provider because the treating provider is not contracted with DentaQuest

#### WASTE/ERROR

- Incomplete or improper anesthesia documentation resulting in excessive reimbursement.
- Improper onlay documentation demonstrating overtreatment of decay.
- Administering periapical radiographs at routine hygiene visits without a specific focused problem.

**These examples above are indicators of waste/error and abuse, however, these examples can result in investigation and prosecution as fraud when knowing willful intent is apparent. Fraudulent intent can be inferred when a pattern of activity has been identified.**

A provider bills appropriately when the service they performed were covered services per the plan design; dentally necessary, meaning the work was needed and there is a long term prognosis, and that the services performed were conducted within the expected standard of care; were coded at the correct level pursuant to the CDT, and were documented appropriately according to the Office Reference Manual (ORM), and consistent with relevant ADA guidelines and state regulations.

DentaQuest may initiate remedial steps to correct identified instances of fraud, waste/error, or abuse, including but not limited to: provider education, recovery of identified overpayments, a corrective action plan with formal monitoring and re-auditing, contract termination, and/or a referral to the MI Office of Inspector General and the MI Attorney General for their independent investigation, and potential criminal and civil penalties.



Pretreatment estimates issued by DentaQuest are not a guarantee of payment. DentaQuest reserves the right to recover dollars for procedures that no longer qualify for the pre-approved estimate of payment; reasons may include lack of dental necessity, do not meet the standards of good dental practice and/or are unsupported in the member's treatment record.

To report fraud, waste/error, or abuse call DentaQuest Fraud Hotline: 800-237-9139 or you may complete the "Report Fraud Form" found at <https://www.dentaquest.com/en/report-fraud>

### **False Claims Act**

While DentaQuest reserves the right to and does review claims submitted by dentists to protect against fraud, waste/error, or abuse and recoup monies paid to providers. The knowing submission of a false claim may also subject you to criminal prosecution under federal and Michigan Medicaid state false claims acts.

#### **Federal False Claims Act (FCA)**

Under the Federal False Claims Act, any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. Liability occurs when an individual:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Conceals or improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement supporting a false claim;
- Presents a false claim for payment or approval

See 31 United States Code (USC) Sections 3729–3733.

#### **State False Claims Acts**

Many states have FCAs that complement the federal law, relating to false or fraudulent claims for under the Medicaid program. These state laws impose civil monetary penalties on individuals or entities that submit false information for purposes of obtaining payment from the State Medicaid Agency. In addition to financial penalties, individuals or entities convicted of false claims act violations can face debarment from Medicaid and possible imprisonment.

#### **Whistleblower Protection**

The Federal FCA, and many State FCAs, permit both the Government and private citizens or "whistleblowers" to bring civil actions for violations of the FCA's liability provisions. When a whistleblower brings such an action, it is brought in the name or on behalf of the Government; the Government has an option to intervene at any time; and must approve any settlement. The FCA prohibits discrimination against any employee taking lawful actions under the FCA. Furthermore, DentaQuest has specific policies regarding the FCA and protections for whistleblowers who bring forward potential false claim actions.

## **9.00 Quality Improvement Program**



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

- Provider satisfaction surveys.
- Random Chart Audits.
- Complaint Monitoring and Trending.
- Peer Review Process.
- Utilization Management and practice patterns.
- Initial Site Reviews and Dental Record Reviews.
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Services Department at 844.876.7917.

#### **10.00 Credentialing Policies**

DentaQuest, in conjunction with the Plan, has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

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

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

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

#### **Appeal of Credentialing Committee Recommendations.**

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

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

#### **Discipline of Providers**

#### **Procedures for Discipline and Termination**

#### **Recredentialing**

Network Providers are recredentialled at least every 36 months.

**If you have credentialing questions, or would like a copy of the aforementioned policies,** please contact DentaQuest's Credentialing Hotline at 800.233.1648 or via e-mail at: [denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com)

#### **11.00 The Patient Record**

**A. Organization**

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

Registration data including a complete health history.

Medical alert predominantly displayed inside chart jacket.

Initial examination data.

Radiographs.

Periodontal and Occlusal status.

Treatment plan/Alternative treatment plan.

Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.

Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
  - a. Health history.
  - b. Medical alert.
  - c. Examination/Recall data.
  - d. Periodontal status.
  - e. Treatment plan.
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

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

1. Adequate documentation of registration information which requires entry of these items:
  - a. Patient's first and last name.
  - b. Date of birth.
  - c. Sex.
  - d. Address.
  - e. Telephone number.
  - f. Name and telephone number of the person to contact in case of emergency.
2. An adequate health history that requires documentation of these items:
  - a. Current medical treatment.
  - b. Significant past illnesses.
  - c. Current medications.
  - d. Drug allergies.
  - e. Hematologic disorders.

- f. Cardiovascular disorders.
  - g. Respiratory disorders.
  - h. Endocrine disorders.
  - i. Communicable diseases.
  - j. Neurologic disorders.
  - k. Signature and date by patient.
  - l. Signature and date by reviewing dentist.
  - m. History of alcohol and/or tobacco usage including smokeless tobacco.
3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
    - a. Significant changes in health status.
    - b. Current medical treatment.
    - c. Current medications.
    - d. Dental problems/concerns.
    - e. Signature and date by reviewing dentist.
  4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
    - a. Health problems which contraindicate certain types of dental treatment.
    - b. Health problems that require precautions or pre-medication prior to dental treatment.
    - c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
    - d. Drug sensitivities.
    - e. Infectious diseases that may endanger personnel or other patients.
  5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
    - a. Blood pressure. (Recommended)
    - b. Head/neck examination.
    - c. Soft tissue examination.
    - d. Periodontal assessment.
    - e. Occlusal classification.
    - f. Dentition charting.
  6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
    - a. Blood pressure. (Recommended)
    - b. Head/neck examination.
    - c. Soft tissue examination.
    - d. Periodontal assessment.
    - e. Dentition charting.
  7. Radiographs which are:
    - a. Identified by patient name.

- b. Dated.
  - c. Designated by patient's left and right side.
  - d. Mounted (if intraoral films).
8. An indication of the patient's clinical problems/diagnosis.
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
  - a. Procedure.
  - b. Localization (area of mouth, tooth number, surface).
10. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
  - a. Periodontal pocket depth.
  - b. Furcation involvement.
  - c. Mobility.
  - d. Recession.
  - e. Adequacy of attached gingiva.
  - f. Missing teeth.
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
  - a. Gingival status.
  - b. Amount of plaque.
  - c. Amount of calculus.
  - d. Education provided to the patient.
  - e. Patient receptiveness/compliance.
  - f. Recall interval.
  - g. Date.
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
  - a. Provider to whom consultation is directed.
  - b. Information/services requested.
  - c. Consultant's response.
13. Adequate documentation of treatment rendered which requires entry of these items:
  - a. Date of service/procedure.
  - b. Description of service, procedure and observation.
  - c. Type and dosage of anesthetics and medications given or prescribed.
  - d. Localization of procedure/observation. (tooth #, quadrant etc.)
  - e. Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:
  - a. Patient examination.

- b. Treatment plan.
- c. Treatment status.

### C. Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.
6. Provider must maintain all member records for a **minimum of 10 years**, in compliance with Michigan Medicaid State and Federal laws.

## 12.00 Patient Recall System Requirements

### A. Recall System Requirement

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

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

- “We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy.”
- “Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help.”

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the “no show” rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

### B. Office Compliance Verification Procedures

In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.

- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- MDHHS indicates reasonable standards for access to dental care services are:
  - Emergency dental – immediately, 24 hours/day, 7 days a week
  - Urgent care- within 48 hours
  - Routine Care – within 21 days

- Preventive Services- within 6 weeks of request
- Initial Appointment- within eight weeks of request
- For services that are not an emergency or urgently needed, but in need of medical attention, appointment availability should be within one week

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

### **13.00 Radiology Requirements**

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

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

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

##### 1. Child – primary dentition

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

##### 2. Child – transitional dentition

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

##### 3. Adolescent – permanent dentition prior to the eruption of the third molars

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

##### 4. Adult – dentulous

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

##### 5. Adult – edentulous

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

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

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

###### a. Child – primary and transitional dentition

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

in either the primary or transitional dentition.

b. Adolescent

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

c. Adult – dentulous

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

d. Adult – edentulous

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

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

1. Child – primary dentition

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

2. Adolescent

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

3. Adult – dentulous

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

3. Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult

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

4. Growth and Development Assessment

a. Child – Primary Dentition

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

of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

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

d. Adult

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

**14.00 Clinical Criteria**

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

The criteria outlined in DentaQuest’s Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association’s Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

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

In addition to the Clinical Criteria located within this Office Reference Manual, DentaQuest can provide additional reference material related to the clinical topics listed below. **If you wish to request information regarding any of these topics, please mail or fax a request to the contact information below:**

DentaQuest, LLC  
 Attn: Utilization Management  
 11100 W. Liberty Drive  
 Milwaukee, WI 55324

Utilization Management Fax: (262) 241-7150

Additional Reference Material for Clinical Guidelines	
Asthma and Oral Health	Non-Fluoride Caries Preventive Agents
Behavior Management during dental treatment of children	Nutrition and Oral Health
Bruxism	Opioids and Dentistry



Caries Diagnostic Methods	Oral Habits and Dentistry
Caries Management	Periodontal Health
Caries Risk Assessment and Prevention	Pregnancy and Oral Health
Childhood Cancer and Oral Health	Prosthetic joint and Dental treatment
Complications in Dentistry	Radiology and Dentistry
Dental Occlusion and Orthodontic Treatment	Routine Preventive Services for Children and Adolescents
Dental Pain	Sealants
Diabetes and Dental Treatment	Sedation - Non IV
Early Childhood caries	Social Determinants of Oral Health
Emergency Dental Treatment	Space Maintainers
Endodontic Therapy	Special Care Dentistry
Fluoride Toothpaste for young children	Stainless Steel Crown
General Anesthesia and Indications for Dental Treatment	Sterilization
Infection Control and Dental Operatories	Third Molar Extractions
Infectious Diseases and Oral health	TMJ Disorders
Infective Endocarditis and Dental Treatment	Tobacco usage, Smokeless Tobacco and Smoking cessation and oral health
IV Sedation	Topical Fluoride
Local Anesthesia	

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 this 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.

**14.01 Criteria for Dental Extractions**

Not all procedures require authorization.

Documentation needed for authorization procedure:

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

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no

overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with four or more extractions in the same quadrant will be covered subject to consultant review.

#### 14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

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

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

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

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

Authorizations for Crowns will not meet criteria if:

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

#### **14.03 Criteria for 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 clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing 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.
- 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 radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

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

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

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

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.

#### 14.04 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

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

All Operating Room (OR) Cases Must be Authorized, **except** for children ages 6 and under. Children 6 and under are automatically approved to receive services in the OR.

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should contact Plan for facility authorization at the number below.

Provider Services: 844.876.7917

#### 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, recent stroke,

new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).

- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

#### **14.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)**

Documentation needed for authorization of procedure:

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

#### Criteria

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

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

Authorizations for Removable prosthesis will not meet criteria:

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

Criteria

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

- When billing for partial and complete dentures, dentists must indicate the date of the initial impressions as the date of service on the claim. Recipients must be eligible on that date in order for the denture service to be covered.

#### **14.06 Criteria for the Excision of Bone Tissue**

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

Code D7471 (CDT 18) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:

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

#### **14.07 Criteria for the Determination of a Non-Restorable Tooth**

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

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

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

#### **14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation**

Documentation needed for authorization of procedure:

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

Criteria

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 7 years old and younger with extensive procedures to be accomplished.

#### **15.00 Loss or Change in Eligibility**

No service is covered after loss of eligibility except for the following services:

- Endodontic Therapy
- Complete and Partial Dentures
- Laboratory-Processed Crowns

Reimbursement for these services is only allowed under the following circumstances:

- Services were started prior to the loss of eligibility.
- For complete or partial dentures and laboratory-processed crowns, impressions were taken prior to the loss of eligibility.
- Services are completed within 30 days of change and/or loss of eligibility.

Conditions not eligible for reimbursement include:

- If a beneficiary's Medicaid eligibility is terminated after extractions were performed, but prior to the initial impressions. The extractions alone do not qualify the beneficiary for dentures.



- Immediate dentures.

The date of service on the claim is the date the endodontic therapy was started or the date of the initial impressions for complete or partial dentures and laboratory-processed crowns.

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**Important Note:**

You may request a hard copy of this Office Reference Manual at no charge by contacting DentaQuest Provider Services at 844.876.7917 or your assigned Provider Engagement Representative.

**APPENDIX A****Attachments****General Definitions**

The following definitions apply to this Office Reference Manual:

- A. **“Contract”** means the document specifying the services provided by DentaQuest to:
- an employer, directly or on behalf of the State of Michigan, as agreed upon between an employer or Plan and DentaQuest (a **“Commercial Contract”**);
  - a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Michigan or its regulatory agencies or Plan and DentaQuest (a **“Medicaid Contract”**);
- B. **“Covered Services”** is a dental service or supply that satisfies all of the following criteria:
- provided or arranged by a Participating Provider to a Member;
  - authorized by DentaQuest in accordance with the Plan Certificate; and
  - submitted to DentaQuest according to DentaQuest’s filing requirements.
- C. **“DentaQuest”** shall refer to DentaQuest, LLC
- D. **“DentaQuest Service Area”** shall be defined as the State of Michigan.
- E. **“Medically Necessary”** means a service or benefit is medically necessary if it is compensable under the Medicaid Program and if it meets any one of the following standards:
- The Service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
  - The service or benefit will, or is reasonably expected to, reduce or ameliorate, the physical, mental, or developmental effects of an illness, condition, injury or disability.
  - The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
- F. **“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 Contract is referred to as a **“Medicaid Member.”** A Member enrolled pursuant to a Medicare Contract is referred to as a **“Medicare Member.”**
- G. **“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.
- H. **“Plan”** is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care

and which provides basic health services to enrolled Members for a fixed prepaid fee.

- I. **“Plan Certificate”** means the document that outlines the benefits available to Members.
- J. **“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 NPI identification number.
- K. **“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.

### **Additional Resources**

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at [www.DentaQuest.com](http://www.DentaQuest.com). Once you have entered the website, click on the “Dentist” icon. From there choose Michigan as your “State” and click on the BCBSM Login and enter User ID and password and press go. Once logged in, select the link “Related Documents” to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Electronic Funds Transfer Form
- Medical and Dental History
- Michigan Desk Reference
- Request for Transfer of Records
- Agreement to Pay Non-covered Services
- HIPAA Companion Guide

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Provider Services at 844.876.7917.

**ADA American Dental Association® Dental Claim Form**

<b>HEADER INFORMATION</b>										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prauthorization <input type="checkbox"/> EPSDT / Title XIX										
2. Predetermination/Prauthorization Number					<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3)					
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>										
3. Company/Plan Name, Address, City, State, Zip Code										
13. Date of Birth (MM/DD/CCYY)			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)					
16. Plan/Group Number					17. Employer Name					
<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11, if none, leave blank.)										
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)					
9. Plan/Group Number			10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)					
<b>RECORD OF SERVICES PROVIDED</b>										
	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.)						34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16						34a. Diagnosis Code(s) A _____ C _____			32. Total Fee	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17						(Primary diagnosis in "A") B _____ D _____				
35. Remarks										
<b>AUTHORIZATIONS</b>					<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>					
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 _____					38. Place of Treatment <input type="checkbox"/> (e.g. 11=office, 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")			39. Enclosures (Y or N) <input type="checkbox"/>		
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 _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)			
					42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			
					44. Date of Prior Placement (MM/DD/CCYY)					
					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident					
					46. Date of Accident (MM/DD/CCYY)			47. Auto Accident State		
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>					
48. Name, Address, City, State, Zip Code					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 _____					
49. NPI			50. License Number		51. SSN or TIN		54. NPI		55. License Number	
					56. Address, City, State, Zip Code			56a. Provider Specialty Code		
52. Phone Number ( ) -			52a. Additional Provider ID		57. Phone Number ( ) -			58. Additional Provider ID		



American Dental Association  
www.ada.org

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

**GENERAL INSTRUCTIONS**

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

**COORDINATION OF BENEFITS (COB)**

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

**NATIONAL PROVIDER IDENTIFIER (NPI)**

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

**ADDITIONAL PROVIDER IDENTIFIER**

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

**PROVIDER SPECIALTY CODES**

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

Category / Description Code	Code
<b>Dentist</b> 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
<b>General Practice</b>	1223G0001X
<b>Dental Specialty (see following list)</b>	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

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

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

ALLERGY	PRE MED	MEDICAL ALERT																													
<b>INITIAL CLINICAL EXAM</b>																															
PATIENT'S NAME _____ <table style="width: 100%; border: none; margin-top: 5px;"> <tr> <td style="width: 33%; text-align: center; border: none;">Last</td> <td style="width: 33%; text-align: center; border: none;">First</td> <td style="width: 33%; text-align: center; border: none;">Middle</td> </tr> </table>			Last	First	Middle																										
Last	First	Middle																													
	GINGIVA <hr/> MOBILITY <hr/> PROTHESIS EVALUATION <hr/> OCCLUSION    I    II    III <hr/> PATIENT'S CHIEF COMPLAINT																														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">OK</td> <td style="width: 5px;"></td> </tr> <tr><td>LYMPH NODES</td><td></td></tr> <tr><td>PHARYNX</td><td></td></tr> <tr><td>TONSILS</td><td></td></tr> <tr><td>SOFT PALATE</td><td></td></tr> <tr><td>HARD PALATE</td><td></td></tr> <tr><td>FLOOR OF MOUTH</td><td></td></tr> <tr><td>TONGUE</td><td></td></tr> <tr><td>VESTIBULES</td><td></td></tr> <tr><td>BUCCAL MUCOSA</td><td></td></tr> <tr><td>LIPS</td><td></td></tr> <tr><td>SKIN</td><td></td></tr> <tr><td>TMJ</td><td></td></tr> <tr><td>ORAL HYGIENE</td><td></td></tr> <tr><td>PERIO EXAM</td><td></td></tr> </table>	OK		LYMPH NODES		PHARYNX		TONSILS		SOFT PALATE		HARD PALATE		FLOOR OF MOUTH		TONGUE		VESTIBULES		BUCCAL MUCOSA		LIPS		SKIN		TMJ		ORAL HYGIENE		PERIO EXAM		<b>CLINICAL FINDINGS/COMMENTS</b>   
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ORAL HYGIENE																															
PERIO EXAM																															
RADIOGRAPHS	B/P	RDH/DDS																													
<b>RECOMMENDED TREATMENT PLAN</b>																															
TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B																												
SIGNATURE OF DENTIST _____		DATE _____																													

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

**RECALL EXAMINATION**

PATIENT'S NAME \_\_\_\_\_

CHANGES IN HEALTH STATUS/MEDICAL HISTORY \_\_\_\_\_

	OK		OK
<b>LYMPH NODES</b>		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

<b>R</b>	<b>WORK NECESSARY</b>														<b>L</b>	
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
<b>LYMPH NODES</b>		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

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

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

### Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): \_\_\_\_\_

Tooth Number(s): \_\_\_\_\_

Date: \_\_\_\_\_

Dentist: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Legal Guardian/  
Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

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



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

**INSTRUCTIONS**

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

**MAINTENANCE TYPE:**

\_\_\_\_\_ Add  
 \_\_\_\_\_ Change (Existing Set Up)  
 \_\_\_\_\_ Delete (Existing Set Up)

**ACCOUNT HOLDER INFORMATION:**

Account Number: \_\_\_\_\_

Account Type: ` \_\_\_\_\_ Checking  
 \_\_\_\_\_ Personal \_\_\_\_\_ Business (choose one)

Bank Routing Number: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Account Holder Name: \_\_\_\_\_

Effective Start Date: \_\_\_\_\_

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

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

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

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

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

# MEDICAL AND DENTAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

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

If yes, what type and where? \_\_\_\_\_

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

Medical Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

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

If yes, please list medications: \_\_\_\_\_

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

If yes, please list: \_\_\_\_\_

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

Do your ankles swell during the day?  Yes  No

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

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

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

Are you on a special diet?  Yes  No

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

If yes, where? \_\_\_\_\_

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

If yes, how often and how much? \_\_\_\_\_

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

Do you have or have you had any disease, or condition not listed?

Yes  No

If yes, please list: \_\_\_\_\_

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

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

# Request for Transfer of Records

I, \_\_\_\_\_, hereby request and give my permission to

Dr. \_\_\_\_\_ to provide Dr. \_\_\_\_\_ any and all information regarding past dental care for \_\_\_\_\_.

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

Please have these records sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

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

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## Agreement to Pay Non-Covered Services

Patient Name: \_\_\_\_\_

Recipient (Medicaid) ID: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Not all dental services are covered by the Blue Cross Blue Shield of Michigan -Healthy Kids Dental Plan. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above named patient, but are not covered services:

### Non-Covered Services

Code	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the above services are not covered by the Blue Cross Blue Shield of Michigan-Healthy Kids Dental Plan, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

*Guarantor Address:*

*Guarantor Phone:*

\_\_\_\_\_  
Street, Apt #

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip

Work: \_\_\_\_\_

# **DentaQuest, LLC**

## **837 Dental Companion Guide**

## 1.0 Introduction

### **Section 1.1 What Is HIPAA?**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting standards will eventually improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in healthcare. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards. The standards were not imposed by the law, but instead were developed by a process that included significant public and private sector input. Covered entities are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically.

#### Additional HIPAA Requirements

- **Privacy:** Standards must be adopted by all health plans, clearinghouses, and providers to ensure the protection and appropriate disclosure of individually identifiable health information.
- **Security:** Standards must be adopted by all health plans, clearinghouses, and providers to ensure the integrity and confidentiality of healthcare information. The security rule addresses healthcare information in all types of media, including hard copy and electronic.
- **National Identifier Codes:** Standards must be adopted by all health plans, clearinghouses, and providers regarding unique identifiers for providers, plans, employers, and individuals (beneficiaries).
- **Enforcement:** The Office of Civil Rights has been appointed to enforce the privacy rule and has been given the authority to levy penalties for compliance failures. CMS has been designated to monitor the transaction and code sets compliance.

Although this Companion Guide deals with only one aspect of the entire "Administrative Simplification" provision, it is worth noting that all covered entities (health plans, clearinghouses, and providers) and their business partners are required to adhere to all aspects of the provision.

### **Section 1.2 Purpose of the Implementation Guide**

The Implementation Guide specifies in detail the required formats for the electronically submitted transaction from a provider to an insurance company, healthcare payer or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within the segments, and was written for all healthcare providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files.

### **Section 1.3 How to Obtain Copies of the Implementation Guides**

The implementation guides for X12N 837 Version 4010A1 and all other HIPAA standard transactions are available electronically at <http://www.wpc-edi.com/>

### **Section 1.4 Purpose of this Companion Guide**

This Companion Guide was created for trading partners to supplement the 837D Implementation Guide. It contains specific information for the following:

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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DentaQuest LLC March 14, 2024

A-71

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- data content, codes, business rules, and characteristics of the transaction;
- technical requirements and transmission options; and
- information on test procedures that each Trading Partner must complete prior to submitting production 837D transactions to DentaQuest.

This guide is specific to electronic interfaces with DentaQuest. The information in this guide supersedes all previous communications from DentaQuest about this electronic transaction.

### **Section 1.5 Intended Audience**

The Companion Guide transaction document is intended for the technical staff of the external entities that will be responsible for the electronic transaction/file exchanges with DentaQuest. The Companion Guide is available to external entities (providers, third party processors, clearinghouses, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with DentaQuest.

### **Section 1.6 Introduction to the 837 Dental Healthcare Claims Transaction**

The 837 transactions under HIPAA is the standard for electronic exchange of information between two parties to carry out financial activities related to a health care claim. The health care claim or equivalent encounter information transaction is the transmission of either of the following:

- A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
- If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

The 837 Health Care Claim transaction set can be used to submit health care claim billing information, encounter information, or both. It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits are required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists and pharmacies and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance benefit. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

This document consists of situational fields for the following transaction type that are required for processing DentaQuest Medicaid Dental claims; however, this document is not the complete EDI transaction format. This companion guide is based on the transaction implementation guide, version:

Dental Transaction ASC X12N 837(004010X097A1)

## **2.0 Trading Partners**

### **Section 2.1 General Overview**

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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DentaQuest LLC March 14, 2024

A-72

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All entities desiring to be a Trading Partner must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile Form for each business entity. To obtain the TPA and Profile Form please contact Provider Services at 844.876.7917. Please note that the profile information may be given over the telephone in lieu of completing a paper form. DentaQuest will assign a Trading Partner ID for your use in electronic transaction exchange and login into DentaQuest's Trading Partner Web Portal.

## **Section 2.2 Establishing Connectivity**

DentaQuest will maintain various methods of exchanging EDI information. DentaQuest has created a Trading Partner Web Portal to allow trading partners to exchange Dental Claim transactions and this is the preferred method of facilitating EDI exchange. The portal allows a Trading Partner to submit and receive transactions. Outgoing transmissions, including all response transactions and functional acknowledgments will be available only through the Trading Partner Web Portal. Other Trading Partner submission methods include SSL FTP. Contact Provider Services at 844.876.7917 with questions about these options.

Encryption is handled automatically as part of SSL (Secured Socket Layer) for the Web Portal or FTP session upon login. Data that pass through the SSL session are encrypted using a 128-bit algorithm and managed via The Verisign<sup>™</sup> Secure Site Program.

## **Section 2.3 Trading Partner Testing**

Prior to submitting production 837D claims, the Trading Partner must complete testing. Testing includes HIPAA compliance as well as validating the use of conditional, optional and mutually defined components of the transaction. Contact Provider Services at 844.876.7917 to discuss the transmission method, testing process and criteria.

- Test files should contain as many types of claims as necessary to cover each of your business scenarios (original claims, void claims, replacement claims (see Section 6.0 for specific data requirements)).

DentaQuest will process these test claims in a test environment to validate that the file meets HIPAA standards and specific data requirements. Once the testing phase is complete and DentaQuest has given its approval, the Trading Partner may submit production 837D transactions to DentaQuest for adjudication. Test claims will not be adjudicated.

## 3.0 Technical Requirements

### Section 3.1 File Size

For 837D transactions, DentaQuest is imposing a limit of 50,000 claim transactions per submission. If you have any questions or would like to coordinate the processing of larger files, please contact Provider Services at 844.876.7917.

### Section 3.2 Naming Convention

Trading Partner Web Portal users may use any convenient file naming convention for their 837D files claims transmitted to DentaQuest. DentaQuest's system will rename files upon receipt and issue a confirmation number for reference. FTP submitted files must adhere to the following naming convention:

Naming Convention: **P837D\_20001\_20061010\_001**

**P** – indicates whether this is a production or test (**T**) file

**837D** – indicates the transaction type

**200001** – indicates the 6 digit trading partner ID

**20061023** – indicates the date the file was sent (YYYYMMDD)

**001** – indicates the sequence number of the file, incremented for subsequent submissions on the same day

### Section 3.3 Multiple Transactions Types In a File

DentaQuest does not allow multiple transaction types to be submitted within a single file submission. While the X12 standards do support the handling of multiple transaction set types to be submitted in a single file (ex. 837D and 276), DentaQuest will not support transaction bundling within a file. Transactions types must be sent separately.

### Section 3.4 Balancing Data Elements

DentaQuest will use any balancing requirements that can be derived from the transaction implementation guides. All financial amount fields must be balanced at all levels available within the transaction set. The number of transactions in the header and footer must equal and be the same as the number of transactions in the file.

## 4.0 Acknowledgments

### Section 4.1 Functional Acknowledgment Transaction Set (997)

DentaQuest uses the 997 transaction to acknowledge receipt of 837D files. The 997 acknowledgements will be available for download from the Trading Partner Web Portal.

The 997 Functional Acknowledgment Transaction is designed to check each functional group in an interchange for data and syntax errors and send results back to the sending trading partner. The 997 can accept or reject records at the functional group, transaction set, or data element level. DentaQuest's 997 Functional Acknowledgment Transaction will report acceptance or rejection at the functional group and transaction set levels.

## 5.0 Support Contact Information

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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DentaQuest LLC March 14, 2024

A-74

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DentaQuest Provider Service phone number: 844.876.7917

## 6.0 SPECIFIC DATA REQUIREMENTS

The following sections outline recommendations, instructions and conditional data requirements for submitting 837D transactions to DentaQuest.

### **Section 6.1 Claim Attachments**

An electronic standard for claim attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, DentaQuest has an alternative method for handling electronic claims that require attachments. If you are enrolled and are using the service offered by National Electronic Attachments (NEA), DentaQuest can accept the assigned NEA control/tracking number when reported in the notes segment (NTE segment). For more information about using NEA to submit electronic attachments contact Provider Services at 844.876.7917 or you may contact NEA directly at [www.nea-fast.com](http://www.nea-fast.com) or 1-800-782-5150.

### **Section 6.2 Predeterminations**

DentaQuest will not accept Predetermination of Benefits Claims.

### **Section 6.3 Coordination of Benefits (COB) Claims**

Submit by paper with primary carrier explanation of benefits attached.

### **Section 6.4 Void Transactions**

Void transactions are used by submitters to correct any of the following situations:

- Duplicate claim erroneously paid
- Payment to the wrong provider
- Payment for the wrong member
- Payment for overstated or understated services
- Payment for services for which payment has been received from third-party payers

Void transactions must be submitted for each service line at a time. For example, if a provider wishes to void a claim that was originally submitted with three service lines, the provider must submit three void transactions. Each transaction is for one of the service lines and must include the original generated DentaQuest Claim Encounter Number (CLP07 from the 835 or Encounter # from paper remittance advice)

## Section 6.5 Detail Data

Submitters can view the entire set of required data elements in the 837D Implementation Guide. It is recommended that submitters pay special attention to the following segments:

### 6.5.01 Control Segments

X12N EDI Control Segments
ISA-Interchange Control Header Segment IEA-Interchange Control Trailer Segment GS-Functional Group Header Segment GE-Functional Group Trailer Segment TA1-Interchange Acknowledgment Segment

### 6.5.02 ISA – Interchange Control Header segment

Reference	Definition	Values
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	[space fill]
ISA03	Security Information Qualifier	00
ISA04	Security Information	[space fill]
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	[DentaQuest-assigned 6 digit Trading Partner ID]
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	DDS391933153
ISA09	Interchange Date	The date format is YYMMDD
ISA10	Interchange Time	The time format is HHMM
ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	1
ISA15	Usage Indicator	T=Test P=Production
ISA16	Component Element Separator	: (Colon)

### 6.5.03 IEA – Interchange Control Trailer

Reference	Definition	Values
IEA01	Number of included Functional Groups	Number of included Functional Groups
IEA02	Interchange Control Number	Must be identical to the value in ISA013

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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#### 6.5.04 GS-Functional Group Header

Reference	Definition	Values
GS02	Application Sender's Code	Must be identical to the values in ISA06
GS03	Application Receiver's Code	DDS391933153
GS04	Date	The date format is CCYYMMDD
GS05	Time	The time format is HHMM
GS06	Group Control Number	Assigned and maintained by the sender
GS07	Responsible Agency Code	X
GS08	Version/Release/Industry Identifier Code	004010X097A1 (Addenda Versions must be used)

#### 6.5.05 GE-Functional Group Trailer

Reference	Definition	Values
GE01	Number of Transactions Sets Included	Number of Transaction Sets Included
GE02	Group Control Number	Must be identical to the value in GS06

#### 6.5.06 Preferred Delimiters

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	123	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

#### 6.5.07 Segment Definitions

**ISA** - Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

**IEA** - Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

**GS** - Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

**GE** - Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

**ST** - Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

**SE** - Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

**6.5.08 837 Dental Healthcare Claim Transaction**

Special attention should be given to the following required segment detail.

Field Definition

Column

- A The name of the loop as documented in the appropriate 837 Implementation Guide.
- B Loop ID used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837 Implementation Guide.
- C The field position number and segment number as specified in the appropriate 837 Implementation Guide.
- D The data element name and page number as indicated in the appropriate 837 Implementation Guide.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Beginning of Hierarchical Transaction		010-BHT02	Transaction Set Purpose Code Pg 55	'00' Original
Beginning of Hierarchical Transaction		010-BHT-06	Transaction Type Code Pg 56	'CH' Chargeable
Submitter Name	1000A	020-NM109	Identification Code Pg 61	[DentaQuest assigned 6 digit Trading Partner ID]
Submitter Contact Information	1000A	020-PER05	Communication Number Pg 65	'TE' Telephone
Receiver Name	1000B	020-NM103	Name Last or Organization Pg 67	DentaQuest

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Receiver Name	1000B	020-NM109	Identification Code Pg 67	DDS391933153
Billing Provider Name	2010AA	015-NM101	Entity Identifier Code Pg 77	'85' Billing Provider
Billing Provider Name	2010AA	015-NM102	Entity Type Qualifier Pg 77	'1' Person '2' Non-Person Entity
Billing Provider Name	2010AA	015-NM103	Billing Provider Name Pg 77	Last Name or Organizational Name
Billing Provider Name	2010AA	015-NM104	Billing Provider Name Pg 77	If NM102= 1, First Name
Billing Provider Name	2010AA	015-NM108	Identification Code Qualifier Pg 78	'XX' National Provider Identifier
Billing Provider Name	2010AA	015-NM109	Identification Code Pg 78	Billing Provider National Provider Identifier
Billing Provider Address	2010AA	025-N301	Address Information Pg 80	Rendering Location Address Line
Billing Provider City/State/Zip Code	2010AA	030-N401	City Name Pg 81	Rendering Location City Name
Billing Provider City/State/Zip Code	2010AA	030-N402	State or Province Code Pg 82	Rendering Location State
Billing Provider City/State/Zip Code	2010AA	030-N403	Postal Code Pg 82	Rendering Location Zip Code (report Zip plus 4)
Billing Provider Secondary Identification Number	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'TJ' Federal Taxpayer's Identification or 'SY' Social Security Number or 'EI' Employer Identification Number
Billing Provider Secondary Identification Number	2010AA	035-REF02	Reference Identification Pg 84	Federal Taxpayer's Identification or Social Security Number or Employer Identification Number

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Pay to Provider's Name	2010AB	015-NM101	Entity Identifier Code Pg 88	'87' Pay-to-Provider
Pay to Provider's Name	2010AB	015-NM102	Entity Type Qualifier Pg 88	'1' – Person '2' – Non-Person Entity
Pay to Provider's Name	2010AB	015-NM103	Name Last or Organization Name Pg 88	Pay-to-Provider Last Name or Organization Name
Pay to Provider's Name	2010AB	015-NM104	Name First Pg 88	If NM102=1, Pay-to-Provider First Name
Pay to Provider's Name	2010AB	015-NM108	Identification Code Qualifier Pg 89	'XX' National Provider Identifier
Pay to Provider's Name	2010AB	015-NM109	Identification Code Pg 89	Pay-to-Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI from 2010AA is used as the pay-to-provider
Pay to Provider's Address	2010AB	025-N301	Address Information Pg 91	Pay-to Provider Address Line
Pay to Provider City/State/Zip	2010AB	030-N401	City Name Pg 92	Pay-to Provider City
Pay to Provider City/State/Zip	2010AB	030-N402	State or Province Code Pg 93	Pay-to-Provider State
Pay to Provider City/State/Zip	2010AB	030-N403	Postal Code Pg 93	Pay-to-Provider Zip Code (report Zip plus 4)
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Qualifier Pg 95	'TJ' Federal Taxpayer's Identification Number of 'SY' Social Security Number or 'EI' Employer Identification Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Qualifier Pg 95	Federal Taxpayer's Identification Number or Social Security Number or Employer Identification Number

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Subscriber Hierarchical Level	2000B	001-HL04	Hierarchical Level Page 97	0-No Subordinate HL Segment in the Hierarchical Structure
Subscriber Information	2000B	005-SBR01	Payer Responsibility Sequence Number Code Pg 99	T-Tertiary
Subscriber Information	2000B	005-SBR09	Claim Filing Indicator Code Pg 102	'MC' Medicaid
Original Reference Number	2300	180-REF01	Reference Identification Qualifier Pg 180	'F8' Original Reference Number
Original Reference Number	2300	180-REF02	Claim Original Reference Number Pg 180	For Claim Frequency Type Code 7 (Replacement Claim) or 8 (Void), report original DentaQuest Encounter Identification Number (CLP07 from the 835 or Encounter # from paper remittance)
Rendering Provider Name	2310B	250-NM101	Entity Identifier Code Pg 196	'82' Rendering Provider
Rendering Provider Name	2310B	250-NM102	Entity Type Qualifier Pg 196	'1' Person
Rendering Provider Name	2310B	250-NM103	Name Last or Organization Name Pg 196	Rendering Provider Last Name
Rendering Provider Name	2310B	250-NM104	Name First Pg 196	Rendering Provider First Name
Rendering Provider Name	2310B	250-NM108	Identification Code Qualifier Pg 197	'XX' National Provider Identifier
Rendering Provider Name	2310B	250-NM109	Identification Code Pg 197	Rendering Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI number from 2010AA is used as the rendering provider.

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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DentaQuest LLC March 14, 2024

A-81

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Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Service Facility Location	2310C	250-NM108	Identification Code Qualifier Pg 204	XX' Health Care Financing Administration National Provider Identifier
Service Facility Location	2310C	250-NM109	Identification Code	NPI reflecting rendering location if you have enumerated. (Typically the Subpart NPI)

## 7.0 APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

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

### Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. [www.x12.org](http://www.x12.org)

### American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. [www.ada.org](http://www.ada.org)

### Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at <http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. <http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>

### Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. [https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa/standard-setting-related-organizations#:~:text=Designated%20Standards%20Maintenance%20Organizations%20\(DSMOs,standards%20or%20modify%20existing%20standards](https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa/standard-setting-related-organizations#:~:text=Designated%20Standards%20Maintenance%20Organizations%20(DSMOs,standards%20or%20modify%20existing%20standards)

### Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. <https://www.hhs.gov/civil-rights/index.html>

### United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. c

### Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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sets. The WPC website is <http://www.wpc-edi.com/>

**Workgroup for Electronic Data Interchange (WEDI)**

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

## **APPENDIX B**

### **Covered Benefits (See Exhibits)**

**This section identifies covered benefits and provides specific criteria for coverage. Providers with benefit questions should contact DentaQuest's Provider Services directly at:**

**844.876.7917**

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

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

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

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

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

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

The benefit tables (Exhibits) 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**

For X12N 837 (version 4010A1) 081309

Health Care Claim Submission Implementation Guide

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- form, that must be submitted when a claim or request for prior authorization is submitted,
- an indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

**DentaQuest Authorization Process**

**IMPORTANT**

For procedures where “Authorization Required” fields indicate “yes”

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

When documentation is requested:

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

When documentation is requested “with claim:”

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

**No Prior Authorization Required/Advisory**

DentaQuest may apply No Prior Authorization Required/Advisory, i.e., “N” status to a service included in a prior authorization (i.e., preservice) request. This status is used when the service does not require prior authorization and/or medical necessity review. In addition, since there is no other denial applied, this means that the service fits within the member’s benefit structure for covered services/exclusions/limitations at the time that the preauthorization request was received. The service was not reviewed, and no decision was applied (i.e. approval or denial).

Members will not be notified if the prior authorization request was deemed 'advisory'. They will receive a notice of approval or denial decisions.

**PLEASE NOTE**

To assure compliance with program benefit parameters when services are designated as “Authorization Required,” Providers must supply the required documentation prior to payment authorization by DentaQuest. Non-emergency treatment initiated and/or completed prior to DentaQuest’s determination of coverage is performed at the financial risk of the dental Provider. If coverage is denied after review by DentaQuest, the treating Provider is financially responsible and may not balance bill the Member, the Plan and/or DentaQuest, LLC. In an emergency situation, the need to prior authorize services is waived. Emergency services are defined as treatment furnished by a Provider qualified to furnish services needed

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to ameliorate pain, infection, swelling, uncontrolled hemorrhage and traumatic injury.

Remember, prior authorization is not a guarantee of payment. Providers are responsible to check recipient eligibility for each date of service, as changes in enrollment status can affect payment eligibility.

## Exhibit A Benefits Covered for Healthy Kids

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

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

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

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

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

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

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0120	Periodic oral evaluation - established patient	0-20		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	N/A
D0140	Limited Oral Evaluation-problem focused	0-20		No	No	Add POS 2-Telehealth when billing for a teledentistry visit.	N/A
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	N/A
D0150	Comprehensive oral evaluation - new or established patient	0-20		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient. One of (D0150) per 36 Month(s) Per Provider.	N/A
D0180	Comprehensive periodontal evaluation - new or established patient	0-20		No	No	One of (D0180) per 12 Month(s) Per patient. Not a covered benefit when billed in conjunction with, or within six months of, other clinical oral evaluation codes.	N/A
D0190	Screening of a patient	0-6		No	No	One of (D0120, D0145, D0150, D0190, D0191) per 6 Month(s) Per Provider.	N/A
D0191	Assessment of a patient	0-20		No	No	One of (D0120, D0145, D0150, D0190, D0191) per 6 Month(s) Per Provider.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D0210	intraoral – comprehensive series of radiographic images	5 - 20		No	No	One of (D0210, D0330, D0372) per 60 Month(s) Per patient.	N/A
D0220	Intraoral - periapical first radiographic image	0-20		No	No	Four of (D0220) per 1 Month(s) Per patient.	N/A
D0230	Intraoral - periapical each additional radiographic image	0-20		No	No	Twelve of (D0230, D0374) per 1 Calendar year(s) Per patient.	N/A
D0240	Intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240) per 36 Month(s) Per patient.	N/A
D0270	Bitewing - single radiographic image	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0373) per 12 Month(s) Per patient.	N/A
D0272	Bitewings - two radiographic images	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0373) per 12 Month(s) Per patient.	N/A
D0273	Bitewings - three radiographic images	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0373) per 12 Month(s) Per patient.	N/A
D0274	Bitewings - four radiographic images	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0373) per 12 Month(s) Per patient.	N/A
D0330	Panoramic radiographic image	5 - 20		No	No	One of (D0210, D0330, D0372) per 60 Month(s) Per patient.	N/A
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	5 - 20		No	No	One of (D0210, D0330, D0372) per 60 Month(s) Per patient.	N/A
D0373	intraoral tomosynthesis – bitewing radiographic image	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0373) per 12 Month(s) Per patient.	N/A
D0374	intraoral tomosynthesis – periapical radiographic image	0-20		No	No	Twelve of (D0230, D0374) per 1 Calendar year(s) Per patient.	N/A



### Exhibit A Benefits Covered for Healthy Kids

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

Space maintainers are a covered service when indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance.

**BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Preventative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D1110	Prophylaxis - Adult	14 - 20		No	No	One of (D1110, D1120) per 6 Month(s) Per patient.	N/A
D1120	Prophylaxis - Child	0-13		No	No	One of (D1110, D1120) per 6 Month(s) Per patient.	N/A
D1206	Topical application of fluoride varnish	0-5		No	No	Four of (D1206) per 12 Month(s) Per patient ages 0 to 5. One of (D1206) per 6 Month(s) Per patient ages 6 and above.	N/A
D1206	Topical application of fluoride varnish	6-20		No	No	Four of (D1206) per 12 Month(s) Per patient ages 0 to 5. One of (D1206) per 6 Month(s) Per patient ages 6 and above.	N/A
D1208	Topical application of fluoride-excluding varnish	6 - 20		No	No	One of (D1208) per 6 Month(s) Per patient ages 6 and above.	N/A
D1351	Sealant - per tooth	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Teeth must be caries free. Sealant will not be covered when placed over restorations.	N/A
D1351	Sealant - per tooth	0-20	Teeth A, B, I - L, S, T	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Teeth must be caries free. Sealant will not be covered when placed over restorations.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Preventative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization 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 placmt of a sealant in radiating non-carious fissure or pits.	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Teeth must be caries free. Sealant will not be covered when placed over restorations.	N/A
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-20	Teeth A, B, I - L, S, T	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Teeth must be caries free. Sealant will not be covered when placed over restorations.	N/A
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	No	One of (D1354) per 1 Lifetime Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient. Up to five teeth may be treated per visit.	N/A
D1510	Space Maintainer - fixed - unilateral	0-13	Teeth A, B, I - L, S, T	No	No	One of (D1510) per 24 Month(s) Per patient per quadrant. Only fixed appliances are reimbursable.	N/A
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	One of (D1516) per 24 Month(s) Per patient. Only fixed appliances are reimbursable.	N/A
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	One of (D1517) per 24 Month(s) Per patient. Only fixed appliances are reimbursable.	N/A
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-13		No	No	One of (D1551) per 24 Month(s) Per patient. Per space maintainer.	N/A
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-13		No	No	One of (D1552) per 24 Month(s) Per patient. Per space maintainer.	N/A
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1553) per 24 Month(s) Per patient. Per space maintainer.	N/A
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1556) per 24 Month(s) Per patient. Per space maintainer.	N/A
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-13		No	No	One of (D1557) per 24 Month(s) Per patient. Per space maintainer.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Preventative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-13		No	No	One of (D1558) per 24 Month(s) Per patient. Per space maintainer.	N/A
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-13	Teeth A, B, I - L, S, T	No	No	One of (D1575) per 24 Month(s) Per patient per quadrant.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

It is DentaQuest's expectation that the Primary Care Dentist (PCD) provide basic and advanced dental services to their patients. However, DentaQuest understands that certain procedures may fall beyond the scope or comfort level of the PCD. To avoid the need for a cumbersome referral process, DentaQuest is leaving the entire process in the hands of the providers. However, DentaQuest's Utilization Management department will continually monitor provider referral patterns to assure appropriate placement of patients and allocation of funds.

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least (24) twenty-four months, unless there is recurrent decay or material failure. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

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

Restorations are not covered for deciduous teeth where exfoliation is expected to occur within 180 days. Restorations of deciduous molars and cuspids are not covered for ages 12 or older, and restorations of deciduous incisors are not covered for ages five or older.

As a condition for payment, it may be necessary to submit, upon request, radiographs and other information to support the appropriateness and necessity of these restorations.

Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER PROSTHETIC SHALL BE BASED ON THE CEMENTATION DATE.**

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**.

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

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - 1 surface, Primary/permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2150	Amalgam - 2 surfaces, Primary/permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2160	Amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2161	Amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2330	Resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2331	Resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2332	Resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2335	Resin-based composite - four or more surfaces (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2390	Resin Based Composite Crown, Anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2390) per 24 Month(s) Per patient per tooth.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2391	Resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2392	Resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2393	Resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2394	Resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2710	Crown - resin-based composite (indirect)	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2712	Crown - 3/4 resin-based composite (indirect)	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2720	Crown - resin with high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2721	Crown - resin with predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2722	Crown - resin with noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2750	Crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2751	Crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2752	Crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative radiographs

**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2780	Crown - 3/4 cast high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2781	Crown - 3/4 cast predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2782	Crown - 3/4 cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2783	Crown - 3/4 porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2790	Crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2791	Crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2792	Crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)



**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2794	Crown- Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2910	Recement or rebond Inlay, Onlay, Veneer or Partial Cov Rest	0-20	Teeth 1 - 32	No	No	One of (D2910) per 6 Month(s) Per patient per tooth.	N/A
D2915	Recement or re-bond indirectly fabricated or Prefabricated Post and Core	0-20	Teeth 1 - 32	No	No	One of (D2915) per 6 Month(s) Per patient per tooth.	N/A
D2920	Recement or rebonding Crown	0-20	Teeth 1 - 32, A - T	No	No	One of (D2920) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement.	N/A
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth A - T	No	No	One of (D2929, D2930, D2931, D2933, D2934) per 24 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement.	N/A
D2930	Prefab. stainless steel crown - primary tooth	0-20	Teeth A - T	No	No	One of (D2929, D2930, D2931, D2933, D2934) per 24 Month(s) Per patient per tooth.	N/A
D2931	Prefab. stainless steel crown - permanent tooth	0-20	Teeth 1 - 32	No	No	One of (D2929, D2930, D2931, D2933, D2934) per 24 Month(s) Per patient per tooth.	N/A
D2933	Prefabricated stainless steel crown with resin window	0-20	Teeth 1 - 32, A - T	No	No	One of (D2929, D2930, D2931, D2933, D2934) per 24 Month(s) Per patient per tooth.	N/A
D2934	Prefab Esthetic Stainless Steel Crn-primary tooth	0-20	Teeth A - T	No	No	One of (D2929, D2930, D2931, D2933, D2934) per 24 Month(s) Per patient per tooth.	N/A
D2940	Protective restoration	0-20	Teeth 1 - 32, A - T	No	No	One of (D2940) per 24 Month(s) Per patient per tooth, per surface.	N/A
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	Yes	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.	Periapical x-ray(s)

**Exhibit A Benefits Covered for  
Healthy Kids**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D2951	Pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	No	One of (D2951) per 24 Month(s) Per patient per tooth.	N/A
D2952	Post and Core in addition to crown-indirect	0-20	Teeth 1 - 32	No	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth.	N/A
D2954	Prefabricated Post and Core in addition to crown	0-20	Teeth 1 - 32	No	No	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth.	N/A
D2999	Unspecified restorative procedure, by report	0-20	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

## Exhibit A Benefits Covered for Healthy Kids

Reimbursement includes local anesthesia.

In cases where a root canal filling does not meet DentaQuest's general criteria 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 the DentaQuest Consultant reviews the circumstances.

The root canal therapy is not covered if the following conditions exist: Furcation pathology is present, a posterior tooth has no opposing tooth, or tooth is not restorable under Medicaid guidelines.

A pulpotomy, pulpectomy 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. Complete root canal therapy includes, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative, fill radiographs, and follow-up care.

**BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.**

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

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3110	Pulp Cap - Direct (excluding final restoration)	0-20	Teeth 1 - 32	No	No	One of (D3110) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-13	Teeth A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3221	Pulpal debridement, primary and permanent teeth	0-13	Teeth 1 - 32, A - T	No	No	One of (D3221) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	5 - 20	Teeth 1 - 32	No	No	One of (D3222) per 1 Lifetime Per patient.	N/A
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-8	Teeth C - H, M - R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-13	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth, per surface.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3346	Retreatment of prev. root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth, per surface.	pre-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3347) per 1 Lifetime Per patient per tooth, per surface.	pre-operative x-ray(s)
D3348	Retreatment of prev. root canal therapy-molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3348) per 1 Lifetime Per patient per tooth, per surface.	pre-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	0-13	Teeth 1 - 32	No	No	One of (D3351) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3352	Apexification/recalcification - interim medication replacement	0-13	Teeth 1 - 32	No	No	One of (D3352) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-13	Teeth 1 - 32	No	No	One of (D3353) per 1 Lifetime Per patient per tooth, per surface. Includes root canal fill.	N/A
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3425) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 32, 51 - 82	No	No	One of (D3426) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3430	Retrograde Filling - per root	0-20	Teeth 1 - 32, 51 - 82	No	No	One of (D3430) per 1 Lifetime Per patient per tooth, per surface.	N/A
D3999	Unspecified endodontic procedure, by report	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)

### Exhibit A Benefits Covered for Healthy Kids

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. It is not covered when a prophylaxis is completed on the same day.

No other periodontal procedures are considered to be covered benefits.

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

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D4341	Perio scaling/root planing - per quad	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	Perio Chart / FMX
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	Perio Chart / FMX
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	0-20		No	No	One of (D4346) per 6 Month(s) Per patient. Not covered when billed on same date of service or within 6 month(s) of (D1110, D1120, D4341, D4342, D4355, D4910).	N/A
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	14 - 20		Yes	No	One of (D4355) per 12 Month(s) Per patient. Not covered in conjunction with (D1110) on the same date of service.	pre-op x-ray(s), perio charting
D4910	Periodontal Maintenance	0-20		No	No	One of (D4910) per 6 Month(s) Per patient. Not covered when billed in conjunction with (D1110, D1120, D4341, D4342, D4346, D4355) on the same date of service.	N/A

## Exhibit A Benefits Covered for Healthy Kids

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

Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary).

Payment for dentures includes any necessary adjustments or relines during the six (6) month period following delivery and routine post delivery care.

Complete or partial dentures are authorized when one or more of the following conditions exist: one or more anterior teeth are missing or there are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth).

Partial dentures are a covered benefit for all beneficiaries over age 16. All clasps are included in the fee for the partial denture.

To replace a lost anterior tooth on a patient under age 16, a claim must be submitted for an interim partial denture and will pend for a professional review.

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

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

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5110	Complete denture - maxillary	0-20		Yes	No	One of (D5110, D5211, D5213, D5225) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	Complete denture - mandibular	0-20		Yes	No	One of (D5120, D5212, D5214, D5226) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	Immediate denture - maxillary	0-20		Yes	No	One of (D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	Immediate denture - mandibular	0-20		Yes	No	One of (D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	16 - 20		Yes	No	One of (D5110, D5211, D5213, D5225) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	16 - 20		Yes	No	One of (D5120, D5212, D5214, D5226) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	16 - 20		Yes	No	One of (D5110, D5211, D5213, D5225) per 60 Month(s) Per patient.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for  
Healthy Kids**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	16 - 20		Yes	No	One of (D5120, D5212, D5214, D5226) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5225	Maxillary Partial Denture - flexible base	16 - 20		Yes	No	One of (D5110, D5211, D5213, D5225) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5226	Mandibular Partial Denture - flexible base	16 - 20		Yes	No	One of (D5120, D5212, D5214, D5226) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5410	Adjust complete denture - maxillary	0-20		No	No	Two of (D5410) per 1 Year(s) Per patient.	N/A
D5411	Adjust complete denture - mandibular	0-20		No	No	Two of (D5411) per 1 Year(s) Per patient.	N/A
D5421	Adjust partial denture - maxillary	0-20		No	No	Two of (D5421) per 1 Year(s) Per patient.	N/A
D5422	Adjust partial denture - mandibular	0-20		No	No	Two of (D5422) per 1 Year(s) Per patient.	N/A
D5511	repair broken complete denture base, mandibular	0-20		No	No	Two of (D5511) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5512	repair broken complete denture base, maxillary	0-20		No	No	Two of (D5512) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5520	Replace missing or broken tooth - complete denture	0-20	Teeth 1 - 32	No	No	Two of (D5520) per 1 Year(s) Per patient.	N/A
D5611	repair resin partial denture base, mandibular	0-20		No	No	Two of (D5611) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5612	repair resin partial denture base, maxillary	0-20		No	No	Two of (D5612) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5621	repair cast partial framework, mandibular	0-20		No	No	Two of (D5621) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5622	repair cast partial framework, maxillary	0-20		No	No	Two of (D5622) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No	No	Two of (D5630) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5640	Replace Broken Teeth - Per Tooth	0-20	Teeth 1 - 32	No	No	Two of (D5640) per 1 Year(s) Per patient per tooth, per surface. Not covered within 6 months of placement.	N/A
D5650	Add Tooth to Existing Partial Denture	0-20	Teeth 1 - 32	No	No	Two of (D5650) per 1 Year(s) Per patient per tooth, per surface. Not covered within 6 months of placement.	N/A
D5660	Add Clasp to Existing Partial Denture	0-20	Teeth 1 - 32	No	No	Two of (D5660) per 1 Year(s) Per patient. Not covered within 6 months of placement.	N/A
D5710	Rebase complete maxillary denture	0-20		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5711	Rebase complete mandibular denture	0-20		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5720	Rebase maxillary partial denture	0-20		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5721	Rebase mandibular partial denture	0-20		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5730	Reline complete maxillary denture (direct)	0-20		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5731	Reline complete mandibular denture (direct)	0-20		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A



**Exhibit A Benefits Covered for  
Healthy Kids**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5740	Reline mandibular partial denture (direct)	0-20		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5741	Reline mandibular partial denture (direct)	0-20		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5750	Reline complete maxillary denture (indirect)	0-20		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5751	Reline complete mandibular denture (indirect)	0-20		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5760	Reline maxillary partial denture (indirect)	0-20		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5761	Reline mandibular partial denture (indirect)	0-20		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient. Not covered within 6 months of placement.	N/A
D5810	Interim complete denture (maxillary)	0-15		Yes	No	One of (D5810) per 24 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5811	Interim complete denture (mandibular)	0-15		Yes	No	One of (D5811) per 24 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (including retentive/clasping materials, rest and teeth), maxillary. Includes any necessary clasps and rests.	0-15	Teeth 6 - 11	Yes	No	One of (D5820) per 24 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5821	interim partial denture (including retentive/clasping materials, rest and teeth), mandibular. Includes any necessary clasps and rests.	0-15	Teeth 22 - 27	Yes	No	One of (D5821) per 24 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for  
Healthy Kids**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D5899	Unspecified removable prosth. proc, by report	0-20		Yes	No		narrative of medical necessity

**Exhibit A Benefits Covered for  
Healthy Kids**

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

Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D6930	Recement Fixed Partial Denture	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No		N/A

### Exhibit A Benefits Covered for Healthy Kids

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D7111) per 1 Lifetime Per patient per tooth.	N/A
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D7140) per 1 Lifetime Per patient per tooth.	N/A
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	2 - 20	Teeth 1 - 32, 51 - 82, A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	One of (D7210) per 1 Lifetime Per patient per tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure.	pre-operative x-ray(s)
D7220	Removal of impacted tooth - soft tissue	2 - 20	Teeth 1 - 32, 51 - 82, A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	One of (D7220) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	Removal of impacted tooth - partially bony	2 - 20	Teeth 1 - 32, 51 - 82, AS - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	One of (D7230) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	Removal of impacted tooth - completely bony	2 - 20	Teeth 1 - 32, 51 - 82, A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	One of (D7240) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	Surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - TS, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	One of (D7250) per 1 Lifetime Per patient per tooth. Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for  
Healthy Kids**

Oral and Maxillofacial Surgery							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D7260	Oroantral Fistula Closure	0-20		No	No	One of (D7260) per 1 Lifetime Per patient.	N/A
D7261	Primary closure of sinus perforation	0-20		No	No	One of (D7261) per 1 Lifetime Per patient.	N/A
D7270	Tooth Reimplant &/or stab. of accid. evulsed tooth	0-20	Teeth 1 - 32	No	No	One of (D7270) per 1 Lifetime Per patient. Includes splinting and/or stabilization.	N/A
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7310) per 1 Lifetime Per patient per quadrant.	N/A
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7310, D7320) per 60 Month(s) Per patient per quadrant.	N/A
D7471	Removal of lateral exostosis (maxilla or mandible)	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7471) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7472	Removal of Torus Palatinus	0-20		Yes	No	One of (D7472) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7473	Removal of Torus Mandibularis	0-20	Per Quadrant (30, 40, LL, LR)	Yes	No	One of (D7473) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7485	Surgical Reduction of Osseous Tuberosity	0-20		No	No	One of (D7485) per 1 Lifetime Per patient per quadrant.	N/A
D7510	Incision/Drain of Abscess - Intraoral soft tissue	0-20	Teeth 1 - 32	Yes	No	Includes routine followup care.	narr. of med. necessity, pre-op x-ray(s)
D7970	Excision of Hyperplastic Tissue-per arch	0-20	Per Arch (01, 02, LA, UA)	No	No	One of (D7970) per 24 Month(s) Per patient per arch.	N/A
D7971	Excision of Pericoronaral Gingiva	0-20	Teeth 1 - 32	No	No	One of (D7971) per 24 Month(s) Per patient per tooth, per surface.	N/A
D7972	Surgical Reduction of Fibrous Tuberosity	0-20		No	No	One of (D7972) per 24 Month(s) Per patient per quadrant.	N/A
D7999	Unspecified Oral Surgery Procedure, BR	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)

## Exhibit A Benefits Covered for Healthy Kids

General Anesthesia and IV Sedation will be reviewed on a case by case basis for medical necessity.

The administration of nitrous oxide, with or without local anesthetic, but without other agents, is not reimbursable.

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

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D9110	Palliative treatment of dental pain – per visit	0-20		No	No	Not allowed with any other services other than radiographs.	N/A
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	No	One of (D9222, D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	No	Seven of (D9223) per 1 Day(s) Per patient. Not allowed on same date as one of (D9239, D9243).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	No	One of (D9222, D9239) per 1 Day(s) Per patient.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	No	Three of (D9243) per 1 Day(s) Per patient. Not allowed on same date as one of (D9222, D9223).	narrative of medical necessity
D9248	Non-intravenous Conscious Sedation	0-5		Yes	No	Not allowed in conjunction with one of (D9222, D9223, D9239, D9243) on same date of service.	narrative of medical necessity
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No	No	One of (D9310) per 12 Month(s) Per patient. Not allowed in same 12 month(s) by provider who billed one of (D0120, D0150).	N/A
D9420	Hospital or ambulatory surgical center call	0-6		No	No	One of (D9420) per 6 Month(s) Per patient in hospital.	N/A
D9420	Hospital or ambulatory surgical center call	7 - 20		No	Yes	One of (D9420) per 6 Month(s) Per patient in hospital. Authorization not required for children ages 0-6.	narrative of medical necessity
D9920	Behavior Management, By Report	0-20		Yes	No	One of (D9920) per 1 Day(s) Per patient. Three of (D9920) per 12 Month(s) Per patient.	narrative of medical necessity
D9930	Tmt of Complications (post surg)-unusual circ, BR	0-20		Yes	No		narrative of medical necessity
D9986	Missed Appointment	0-20		No	No		N/A

**Exhibit A Benefits Covered for  
Healthy Kids**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Pre-Payment Review Required	Prior Authorization Required	Benefit Limitations	Documentation Required
D9987	Cancelled Appointment	0-20		No	No		N/A
D9999	Unspecified Adjunctive Procedure, By Report	0-20		Yes	No		narrative of medical necessity