DSM USA Insurance Company Inc.

Office Reference Manual

AmeriHealth Caritas - Ohio

PO Box 2906
Milwaukee, WI 53201-2906
855.208.6575
www.dentaquest.com

DSM USA Insurance Company Inc.

Address and Telephone Numbers

Provider Services
PO Box 2906
Milwaukee, WI 53201-2906
855.208.6575

Fax numbers:
Claims/payment issues: 262.241.7379
Claims to be processed: 262.834.3589
All other: 262.834.3450

Claims Questions:
denclaims@dentaquest.com

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

Customer Service/Member Services
833.764.7700
24 Hour Emergency Line: 833.625.6446
OhioRise Members: 833.711.0773

Fraud Hotline
800.237.9139

Credentialing
https://managedcare.medicaid.ohio.gov/

Authorizations should be sent to:
DENTAQUEST of OH-Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

Claims should be sent to:
DENTAQUEST of OH-Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Online via Provider Portal
https://govservices.dentaquest.com/
or
Via Clearinghouse Payer ID CX014

Include the following address
DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

DSM USA Insurance Company Inc.

Statement of Members' Rights and Responsibilities

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

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

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

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

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

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

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

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

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need 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.

DSM USA Insurance Company Inc.

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest.

3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.

4. Supply accurate, relevant, factual information to a member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by Plan/DentaQuest.

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

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

* * *

DentaQuest makes every effort to maintain accurate information in this manual; however, we 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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APPENDIX B Covered Benefits

Benefits Covered

1.00 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

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

1.02 Member Identification Card

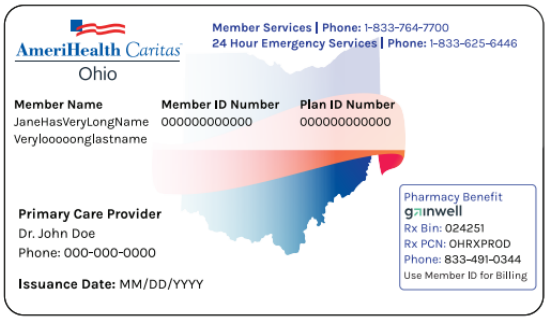
Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

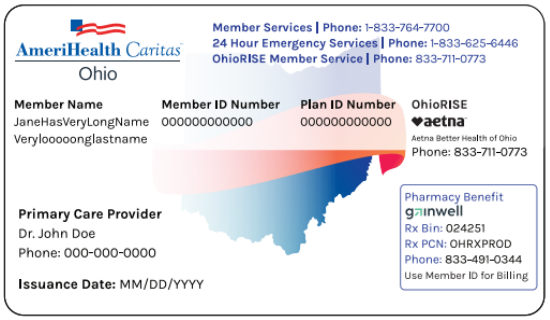
Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

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 alone does not guarantee that a person is currently enrolled in the Health Plan.

Sample of AmeriHealth Plan I.D. Cards





1.03 DentaQuest Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest' s Interactive Voice Response (IVR) system or through the provider web portal at https://govservices.dentaquest.com/. The eligibility information received from either system will be the same information you would receive by calling DentaQuest' s Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information online
DentaQuest currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility online by entering the Member's date of birth, the expected date of service, and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest' s provider portal, simply visit https://govservices.dentaquest.com/. You will then be able to log in using your username and password. First time users will have to register by utilizing the Business's TIN, State, and Business Key. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest' s Customer Service Department at 855.208.6575. Once logged in, select "Eligibility → Member Eligibility Search" and enter the applicable information for each Member you are inquiring about. You can check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line
To access the IVR, simply call DentaQuest' s Customer Service Department at 855.208.6575 and press 1 for eligibility. The IVR system will be able to answer all your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service at 855.208.6575.
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.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 855.208.6575. They will be able to assist you in utilizing either system.

1.04 State Eligibility System

Ohio Department of Job and Family Services
800.686.1516

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 obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest' s Customer Service Department.

2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

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

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

A. Authorization and documentation submitted before non-emergency treatment begins.

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 new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit http://www.nea-fast.com/ and click the "Learn More" button. To register, visit https://vynedental.com/fastattach/ and select "Register Now."
- 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.

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.

2.02 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.

2.03 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 or call NEA at 800.782.5150.

2.04 Dispute Resolution /Provider Appeals Procedure

Participating Providers that disagree with 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 60 days from the date of the original determination to be reconsidered by DentaQuest' s Peer Review Committee.

DentaQuest,
Attention: Utilization Management/Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906

All notices received shall be submitted to DentaQuest' s Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider.

2.05 EMERGENCY Treatments and Authorizations

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

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

3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Provider should submit services for dental care to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should use the information below for facility authorization if applicable.

For Medical Prior Authorizations you may submit your request on the AmeriHealth Provider Portal or call directly.

Submitting on AmeriHealth Provider Portal

https://govservices.dentaquest.com/

Here is the navigation break down: Claims/Pre-Authorizations/ Referrals → Dental Pre-Auth Entry

Approval will be available on provider portal and faxed to provider.

4.00 Claim Submission Procedures (claim filing options)

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

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

4.01 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 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.

4.02 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 visit https://govservices.dentaquest.com/. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's TIN, State, and Business Key. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest' s

Customer Service Department at 855.208.6575. Once logged in, select “Claims/Pre-Authorizations/ Referrals” and then “Dental Claim Entry”. The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports, and charts) to the claim.

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

EDITeam@greatdentalplans.com

4.03 Electronic Authorization Submission Utilizing DentaQuest’ s Internet Website

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

To submit pre-authorizations via the provider portal, simply visit https://govservices.dentaquest.com/. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s TIN, State, and Business Key. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’ s Customer Service Department at 855.208.6575. Once logged in, select “Claims/Pre-Authorizations/ Referrals” and then “Dental Pre-Auth Entry”.

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

4.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon 1-888-363-3361, Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, and Secure EDI 1-877-466-9656 for claim submissions to DentaQuest.

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

4.05 HIPAA Compliant 837D File

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

4.06 NPI and Medicaid ID Requirements for Claims Submission

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

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.

- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- Providers must register for the appropriate Medicaid ID with ODM at https://portal.ohmits.com/Public/Providers/Enrollment and provide this information to DentaQuest in its entirety.
- When submitting claims to DentaQuest you must submit all forms of NPI and Medicaid ID 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 follows the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

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

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

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

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

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

  Claims should be mailed to the following address:

DENTAQUEST of OH, Claims
PO Box 2906
Milwaukee, WI 53201-2906

4.08 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.

4.09 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.

4.10 Receipt and Audit of Claims

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

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

4.11 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 the website (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 Mail – DentaQuest, ATTN: PDA Department PO Box 2906 Milwaukee, WI 53201-2906

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 https://govservices.dentaquest.com/.
2. Log in using your password and ID
3. Once logged in, select "Claims/Pre-Authorizations/Referrals" and then "Explanation of Benefits".
4. The remittance list will display on the screen.

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which are 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 (CDT-5) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-5 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

  Note: Copies of DentaQuest' s HIPAA policies are available upon request by contacting DentaQuest' s Customer Service department at 855.208.6575 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

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

6.00 Inquiries, Complaints and Grievances (Policies 200.010, 200.011, 200.013, 200.017)

DentaQuest adheres to State, Federal, and Plan requirements related to processing inquiries, complaints, and grievances. Unless otherwise required by Agency and Plan, DentaQuest processes such inquiries, complaints, and grievances consistent with the following:

A. Inquiry: An inquiry is the first contact with the Plan (verbal or written) expressing dissatisfaction from the Member, an attorney on behalf of a Member, or a government agency.

B. Complaint: A complaint is an expression of dissatisfaction (written or verbal) from a Member, an attorney on behalf of a Member, or a government agency registering a request for review of a prior decision.

C. Grievance: A notice sent by a Member or attorney on behalf of a Member registering a request for formal review of a complaint decision. Issues categorized as grievances have progressed through the inquiry, and complaint levels of the process resulting in a Member's dissatisfaction with the outcome of issue review.

D. DentaQuest' s Complaints/Grievance Coordinator receives Member and Provider inquiries and complaints. The Coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified of the resolution (i.e. Plan, Member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes. Any member and any provider acting on behalf of a member with the member's consent may appeal any utilization management determination resulting in a denial, reduction, suspension or termination of dental services.

E. The Complaints/Grievances Coordinator receives Member and Provider grievances. The Coordinator requests appropriate documentation forwards the documentation to the dental consultant for review and determination, and the decision to uphold or overturn the initial decision is communicated to the appropriate individuals.

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 855.208.6575. (Policies 200.010, 200.011, 200.013, 200.017)

6.01 Member Complaint Submission

A. Members have the right to submit a complaint to DentaQuest at any time. The complaint can be regarding any dispute the Member or Authorized Representative has with DentaQuest.

B. Members have the right to assign a Representative. The Representative can be any individual of the Member's choosing: spouse, family Member, attorney, Provider, POA, guardian, etc.

C. The complaint is not required to be written. Verbal requests are accepted and do not require written and signed documentation from the Member or Authorized Representatives.

D. A Member or Authorized Representative can submit a verbal complaint by calling DentaQuest using the designated Toll-Free number with TDD/TTY services based on their plan.

E. A Member's written complaint may be submitted to DentaQuest' s Complaints & Grievances Department at the following address:

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

7.00 Utilization Management Program

7.01 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, State, or Federal government. The source of dollars varies depending on the program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These "budgeted" dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

7.02 Community Practice Patterns

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

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest' s Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

7.03 Evaluation

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

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

7.04 Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, DentaQuest' s Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

7.05 Fraud and Abuse

DentaQuest is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.

If there is any suspicion of Fraud and Abuse, please utilize the Hotline number provided below:

Fraud Hotline
800.237.9139

8.00 Quality Improvement Program (Policies 200 Series)

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

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

A copy of DentaQuest' s Quality Improvement Program is available upon request by contacting DentaQuest' s Customer Service Department at 855.208.6575 or via e-mail at:

denelig.benefits@dentaquest.com

9.00 Credentialing (Policies 300 Series)

Effective 10/01/2022, Ohio Medicaid and MyCare providers will utilize the Provider Network Management (PNM) module from the Ohio Department of Medicaid for submitting provider applications, credentialing request, and provider demographic updates. The PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service. The PNM module is replacing MITS provider portal. Please visit https://managedcare.medicaid.ohio.gov/ for further details.

A provider must be registered with Ohio Department of Medicaid, have a valid OH Medicaid Dental License, Medicaid ID, and NPI to contract with DentaQuest.

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. (Policy 300.017)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

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

Discipline of Providers (Policy 300.019)
The Credentials Committee, in its sole discretion or upon recommendation by the Peer Review Committee, may discipline a participating Provider for substandard performance, failure to comply with the administrative requirements, or the professional criteria, or any other reason the Credentials Committee deems appropriate.

Procedures for Discipline and Termination (Policies 300.017-300.025)
Where the Credentials Committee determines that remedial action was or will be ineffective to the adverse actions, it may suspend, terminate, or restrict the participation of a Provider and remove them from all network directories.

Recredentialing (Policy 300.016)
All existing providers must be reviewed every 36 months from the date of their previous credentialing action.

Note: The policies are available upon request by contacting DentaQuest' s Customer Service at 855.208.6575 or via e-mail at:

denelig.benefits@dentaquest.com

10.00 The Patient Record

A. Organization

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

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

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

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

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

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

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

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. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation e.g., tooth, quadrant, etc.
    e. Signature of the Provider who rendered the service.

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

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

C. Compliance

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

11.00 Patient Recall System Requirements

A. Recall System Requirement

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

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

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

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

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

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.
- Urgent care must be available within 48 hours.
- Emergency care must be available within 24 hours.

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

12.00 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 with posterior bitewings for a new adolescent patient.

4. Adult – dentulous

   The Panel recommends an individualized radiographic examination consisting of selected periapical 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 to 12 months 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 based on prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

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

a. Child – primary dentition

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

b. Adolescent

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

c. Adult – dentulous

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

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

The Panel recommends an individualized radiographic survey consisting of selected periapical 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 (16-19 years of age) recall patient, a single set of Periapical of the wisdom teeth OR a panoramic radiograph.

d. Adult

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

13.00 Health Guidelines – Ages 0-18 Years

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

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)
Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

PERIODICITY RECOMMENDATIONS					
Age (1)	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Oral Hygiene Counseling (2)	**Parents/ guardians/ caregivers**	**Parents/ guardians/ caregivers**	**Patient/parents/ guardians/ caregivers**	**Patient/ parents/ caregivers**	**Patient**
Injury, Prevention Counseling (3)	**X**	**X**	**X**	**X**	**X**
Dietary Counseling (4)	**X**	**X**	**X**	**X**	**X**
Counseling for non-nutritive habits (5)	**X**	**X**	**X**	**X**	**X**
Fluoride Supplementation (6,7)	**X**	**X**	**X**	**X**	**X**
Assess oral growth and development (8)	**X**	**X**	**X**	**X**	**X**
Clinical oral exam	**X**	**X**	**X**	**X**	**X**
Prophylaxis and topical fluoride treatment (9)		**X**	**X**	**X**	**X**
Radiographic assessment (10)			**X**	**X**	**X**
Pit and Fissure Sealants			**If indicated on primary molars**	**First permanent molars as soon as possible after eruption**	**Second permanent molars and appropriate premolars as soon as possible after eruption**
Treatment of dental disease	**X**	**X**	**X**	**X**	**X**
Assessment and treatment of developing malocclusion			**X**	**X**	**X**
Substance abuse counseling				**X**	**X**
Assessment and/or removal of third molars					**X**
Referral for regular periodic dental care					**X**
Anticipatory guidance (11)	**X**	**X**	**X**	**X**	**X**

1. **First examination at the eruption of the first tooth and no later than 12 months.**
2. **Initially, responsibility of parent; as child develops jointly with parents, then when indicated, only by child.**
3. **Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing.**
4. **At every appointment discuss role of refined carbohydrates, frequency of snacking.**
5. **At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.**
6. **As per American Academy of Pediatrics/American Dental Association guidelines and the water source.**
7. **Up to at least 16 years.**
8. **By clinical examination.**
9. **Especially for children at high risk for caries and periodontal disease.**
10. **As per AAPD Guideline on Prescribing Dental Radiographs.**
11. **Appropriate discussion and counseling should be an integral part of each visit for care.**

14.00 Clinical Criteria

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

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

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria are both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your program. In addition, there may be additional program specific criteria regarding treatment. Therefore, it is essential you review the Benefits Covered Section before providing any treatment.

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

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

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

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

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. If radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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

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

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, periapical, 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 is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

- 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.
- The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

1. Documentation of medical necessity for oral surgery - evidence of diagnosed pathology or demonstrable need rather than anticipated future pathology.

a. Pathology

i. Provider must submit narrative and x-rays or photos describing pathology

ii. Each tooth must show pathology

iii. Symptomology or impactions without pathology may not be enough

b. Demonstrable need

i. Narrative describing need

ii. Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)

2. General Approval vs. Denial Guidelines

a. Probable Approval

i. Pathology =

1. Non-restorable Decay

2. Tooth erupting on an angle and impinging on 2nd molars

3. Recurrent Pericoronitis

4. Dentigerous Cyst or other growth

5. Internal or External Root Resorption

6. 3rd molar has over-erupted due to lack of opposing tooth contact

ii. Demonstrable need =

1. **Pain with no pathology** – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need

b. Probable Denial

i. Impaction or Symptomology =

1. Impaction with no other pathology

2. Pain or discomfort with unknown pathology

3. Absence of root formation indicating tooth is pre-eruptive

ii. Other 3rd molars have pathology (if one, two or three teeth show pathology, DentaQuest will not automatically approve the extraction of the remaining non-pathologic teeth)

3. Denials

a. If administrative denial (e.g. lack of documentation):

i. Resubmit according to deficiencies noted in EOB

b. If clinical denial:

i. Resubmit with documentation showing additional clinical evidence for extraction

ii. Advise member service is not covered

1. Member can appeal following appeal process in member handbook

2. Provider and member may work out an out of pocket arrangement

The removal of primary teeth whose exfoliation is imminent does not meet criteria.

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

Criteria

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

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

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

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

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

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has sub-osseous and/or furcation involvement.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay.
- An existing crown is present with chipped or fractured porcelain without decay.
- Crowns are being planned for cosmetic reasons
- The overall dental condition of the teeth and gums of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapical or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph

of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

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

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries sub crestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

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

14.04 Criteria for Stainless Steel Crowns

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, periapical, 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 sub osseous 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.

14.05 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.

Providers should refer to section 3.00, Participating Hospitals for further clarification on hospital authorization procedures.

Criteria

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

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

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

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

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.

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

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.

- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapical, 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 8 years old and unserviceable to qualify for replacement.

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

- 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 8 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 eight 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.

- For complete dentures, if the natural teeth have healthy bone, are sound, and do not have to be extracted.

Criteria

- If there is a pre-existing prosthesis, it must be at least 8 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 8 years of age usually will not meet criteria for pre-authorization of a new denture.

- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date of impression as the date of service, but a claim should not be submitted until the partial or complete denture has been delivered to the patient.

14.07 Criteria for the Excision of Bone Tissue

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

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

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, periapical or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis(es) to be removed.

14.08 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

14.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization.
Documentation needed for authorization of procedure:

- Radiographs – periapical or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.
- Periodontal History

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

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

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

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

Criteria

A minimum of four (4) teeth affected in the quadrant.

Periodontal charting indicating abnormal pocket depths in multiple sites.

Additionally, at least one of the following must be present:

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

APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

A. "ODM" means the Ohio Department of Medicaid.

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

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

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

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

D. "DentaQuest" shall refer to DentaQuest,

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

F. "Medically Necessary" means those Covered Services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to prevent disease, disability and other adverse health conditions or their progression, or prolong life. In order to be Medically Necessary, the service or supply for medical illness or injury must be determined by Plan or its designee in its judgement to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical practice in the community.

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

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

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

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

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

L. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

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 www.DentaQuest.com. Once you have entered the website, click on the “Dentists” icon. From there choose your ‘State” and press go. You will then be able to log in using your password and User ID. Once logged in, select the link “Related Documents” to access the following resources:

- Ohio Orthodontic Criteria for Medical Necessity
- Referral Evaluation Criteria for Comprehensive Orthodontic Treatment
- Orthodontic Services
- Orthodontic Continuation of Care Form
- Ortho CAD Submission Form
- 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
- Provider Change Form
- Request for Transfer of Records
- HIPAA Companion Guide

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service at 855.208.6575.

You may also scroll down to find these forms included in this document.

DentaQuest

Models ___
OrthoCAD _
Lateral Ceph
X-Rays ___
Photos ___
Narrative ____

DentaQuest,

OHIO ORTHODONTIC CRITERIA FOR MEDICAL NECESSITY

Patient Name: _____ **DOB:** _____

HealthPlan: _____ **Doctor Name:** _____

CRITERIA	YES	NO
Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
True anterior open bite (skeletal) involving 3 or more fully erupted teeth - viewed from a frontal view.		
Demonstrates a large anterior –posterior discrepancy. Class II and Class III malocclusions that are virtually a full tooth (greater than full step) Class II or Class III.		
Anterior crossbite of 3 or more teeth in the same arch		
Posterior transverse discrepancies. (Involves 3 or more maxillary posterior teeth in crossbite, one of which must be a molar).		
Significant posterior open bites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
Impacted anterior teeth that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where canines are going to erupt ectopically).		
Congenital, Developmental, or Traumatic Deformity with significant accompanying dental deformity.		
Documented Psychological, Speech, or eating disorders that would be ameliorated by orthodontia. Documented from professionals within their scope of practice.		

Ohio Department of Medicaid

REFERRAL EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Individual	Provider
Name	Name
Medicaid ID number	Medicaid provider number
Date of birth	NPI

Mark all symptoms and indications that you observe in this patient.

Dentofacial Abnormality

- ☐ Marked protrusion of upper jaw and teeth
- ☐ Underdevelopment of lower jaw and teeth, receding chin
- ☐ Excessive spacing of front teeth
- ☐ Protrusion of upper or lower teeth such that lips cannot be brought together without strain
- ☐ Marked protrusion of lower jaw and teeth
- ☐ Marked crookedness, crowding, irregularity, or overlapping of teeth
- ☐ Marked asymmetry of lower face or transverse deficiency
- ☐ Cleft of lip or palate
- ☐ Abnormality of dental development
- ☐ Condition that increases likelihood of injury to teeth
- ☐ Condition that complicates or exacerbates TMJ dysfunction or another medical problem
- ☐ Other (Explain on the reverse side of the page.)

Tissue Damage Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked recession of gums
- ☐ Loosening of permanent teeth
- ☐ Other (Explain on the reverse side of the page.)

Mastication Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked grimacing or motions of the oral-facial muscles when swallowing or difficulty in swallowing
- ☐ Socially unacceptable eating behavior caused by necessary compensation for anatomic facial deviations
- ☐ Pain when eating
- ☐ Other (Explain on the reverse side of the page.)

Respiration or Speech Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Postural abnormalities with associated breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth-breathing
- ☐ Lisping, articulation errors, or other speech impairment
- ☐ History of or recommendation for speech therapy
- ☐ Other (Explain on the reverse side of the page.)

Adverse Psychosocial Impact Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ (Explain on the reverse side of the page. Supporting statements may be attached from professionals, the patient, or the patient's family concerning the adverse impact on self-image, social interaction, or other psychological or social aspect of life.)

Signature	Date

ODM 03630 (Rev. 1/2016)

ORTHODONTIC SERVICES

Comprehensive Orthodontics

Coverage of comprehensive orthodontics is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient. Orthodontic service is medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Purely cosmetic orthodontic service is not covered. Coverage is further limited to children under age 21. Only one course of orthodontic treatment per recipient, per lifetime is covered.

Prior authorization is required for all comprehensive orthodontic treatment. The following must be included with the prior authorization request:

1) **A completed 2006 or newer ADA claim form**
2) **Lateral and frontal photographs of the patient with lips together (D0471)**
3) **Cephalometric film with lips together, including a tracing (D0340)**
4) **A complete series of radiographs or a panoramic radiograph (D0210 or D0330)**
5) **Diagnostic models (D0470)**
6) **Treatment Plan, including projected length and cost of treatment**
7) **Completed Referral Evaluation Criteria Form (ODHS 3630)**

A patient must demonstrate a minimum of five (5) symptoms, with at least two (2) of the symptoms appearing under dentofacial abnormality before the provider considers submitting a request for consideration.

Continuation of Care Submission Form

Date:_____

Patient Information

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

Provider Information

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

Name of Previous Vendor that issued original approval:

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

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

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

Balance Expected for Future Dates of Service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

If approved through a prior Medicaid vendor, please submit the following:
- A complete Orthodontic Continuation of care form
- A completed 2006 or greater ADA claim form listing the services to be rendered
- A copy of the member's prior approval letter including the total approved case fee and payment structure
- Detailed payment history

If approved through a private arrangement or commercial plan also include:
- A copy of the original study models or a complete set of diagnostic photographs prior to the patient being banded
- Panorex film

Mail to: DentaQuest
Attn: Continuation
PO Box 2906
Milwaukee, WI 53201-2906

Ortho CAD Submission Form

Date:_____

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

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

Treatment Requested

Code:	**Description of request:**

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

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

7. Gender ☐M ☐F ☐U

8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

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

14. Gender ☐M ☐F ☐U

15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

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

19. Reserved For Future Use

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

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

22. Gender ☐M ☐F ☐U

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

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

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

39. Enclosures (Y or N) ☐

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

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

42. Months of Treatment

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

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

45. Treatment Resulting from
☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

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

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J435D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

ADA

American Dental Association
www.ada.org

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

GENERAL INSTRUCTIONS

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

COORDINATION OF BENEFITS (COB)

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

ADDITIONAL PROVIDER IDENTIFIER

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

PROVIDER SPECIALTY CODES

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

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

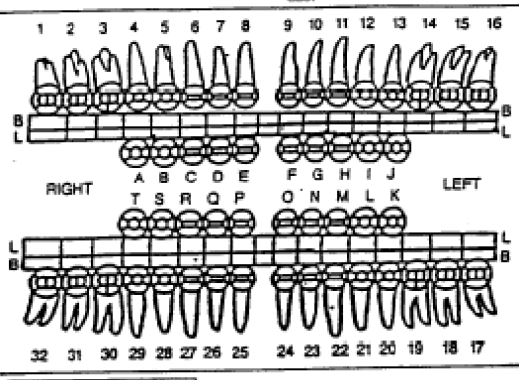
Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

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

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA

MOBILITY

PROSTHESIS EVALUATION

OCCLUSION I II III

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

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

Authorization for Dental Treatment

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

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

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

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

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

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

Are you on a special diet? □ Yes □ No

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

If yes, please list: _____

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

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

For Women Only:

Are you pregnant? □ Yes □ No

If yes, what month? _____

Are you nursing? □ Yes □ No

Are you taking birth control pills? □ Yes □ No

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

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

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

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

Provider Change Form

Provider Name		
Provider NPI		
Tax ID		
Location Address	**GID #**	
Location Address	**GID#**	
Location Address	**GID#**	

Please check the box preceeding the change (s) you would like to have made to the providers record.

		Current Info	New Info	Effective Date
Provider Demographic Changes				
	Name (provide proof of name change)			
	Date of Birth			
	Degree			
	Social Security #			
	Gender			
	Medicaid number update			
	Dental Home Update			
	Provider NPI			
	Correspondence Address			
Provider License Updates				
	Dental License			
	DEA			
	Anesthesia License			
Location Changes				
	Service Office name			
	Service office Address			
	Phone number			
	Fax Number			
	Age Limitations			
	Office Hours			
	Not on directory			
	Existing Patients Only			
	Term provider from this location			
	Dental Home/ Capitation Attributes			
Business Changes				
	Business Name Change - You must submit a new contract and W9 along with this request			
	Tax ID Change - you must submit a new contract and W9 along with this request			
	Business NPI			
Add a new location				
	Add credentialed provider to a new location under the existing Tax ID indicated above			
	Add credentialed provider to an existing location			
Payment Address Changes				
	Change address where EOB's are sent			
	Add or Change EFT information - you must submit the EFT form and a voided check with this request			

This form may be submitted by

Mail to: DentaQuest Credentialing 12121 N. Corporate Parkway Mequon WI 53092

Email to: standardupdates@dentaquest.com

Fax to: 262-241-4077

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: _____

Acknowledgment of Disclosure and Acceptance
Member Financial Responsibility for Non-Covered Services
CONSENT FORM

Member Name: _____

Member ID: _____

Treating Provider Name: _____
Service Location Name and Address: _____

Not all dental services are covered by your health plan. Some services are covered, but only within specific time frames (twice per year, once per year, once every 5 years, etc.) Services requested or received more frequently than your benefit allows are non-covered. Some services also have criteria that must be met to be covered. This is called "medical necessity". If the service is not medically necessary, the service is not covered. The following service(s) are recommended for the above-named patient, but are not covered services:

Non-Covered Services

Code	Cost	Description	Reason service is not covered

I understand that the above services are not covered by my health plan, and that I am personally responsible for paying the dentist if I choose to receive these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

_____ _____
Member Signature Date

_____
Witness Signature

CONSENT FOR PROVIDER TO FILE AN APPEAL ON MEMBER'S BEHALF

Provider Information:

Provider Name:	Provider NPI:
Group Name:	Phone Number:
Address, City, State and ZIP:	

DESCRIPTION OF SERVICES TO BE APPEALED, INCLUDING DATES OF SERVICE: _____

Please be sure to also include all necessary clinical and other supporting documentation for the appeal.

MEMBER INFORMATION AND CONSENT: I give consent for the provider listed above to file an appeal on my behalf with AmeriHealth. This will be an appeal for the denial of health care services issued by AmeriHealth that is described above. I have read this consent or have had it read to me and it has been explained to my satisfaction.

Member Name:	Member ID:	Date of Birth:
Address, City, State and ZIP:		Phone Number:
Member Signature:		Date:

CONSENT FROM A REPRESENTATIVE: The member listed above is unable to sign this consent form because of the reason(s) listed below, and I consent for the member:

If signed by someone other than the member/minor member's parent, you must provide a copy of the power of attorney or court document showing authority to act on the member's behalf, if you have not already done so. Please complete the following fields:

Representative Name:	Representative Phone Number:	Relationship to Member:
Representative Signature:		Date:
Witness Name:	Witness Signature:	Date:

APPENDIX B

Covered Benefits (See Exhibits)

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

855.208.6575, press option 2

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

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

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

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

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

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

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

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether the service is subject to prior authorization, any other applicable benefit limitations.

Exhibit B

Benefits Covered for AmeriHealth Child, Child ABD, and CIC (21 years and older)

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

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 4 Month(s) Per patient. One of (D0120, D0150) per 4 Month(s) Per Provider.	
D0140	limited oral evaluation-problem focused	21 and older		No		
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 60 Month(s) Per Provider OR Location. One of (D0120, D0150) per 4 Month(s) Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 1 Year(s) Per patient. Not reimbursable on the same day as a D0120 and D0150.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	21 and older		No		
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0321	other temporomandibular joint films, by report	21 and older		Yes		
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0340	cephalometric radiographic image	21 and older		Yes	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	21 and older		Yes	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	21 and older		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0470	diagnostic casts	21 and older		No	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0604	antigen testing for a public health related pathogen, including coronavirus	21 and older		No		
D0605	antibody testing for a public health related pathogen, including coronavirus	21 and older		No		

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

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

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	One of (D1206) per 6 Month(s) Per patient.	
D1320	tobacco counseling for control and prevention of oral disease	21 and older		No	Two of (D1320) per 12 Month(s) Per patient.	
D1321	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	21 and older		No	Two of (D1321) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1354) per 1 Day(s) Per patient per tooth. Four of (D1354) per 1 Day(s) Per patient. Maximum four teeth per date of service.	
D1355	caries preventive medicament application – per tooth	21 and older	Teeth 1 - 32, A - T	No	Maximum four teeth per date of service.	
D1510	space maintainer-fixed, unilateral-per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1516	space maintainer --fixed--bilateral, maxillary	21 and older		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1517	space maintainer --fixed--bilateral, mandibular	21 and older		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1520	space maintainer-removable-unilateral	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1526	space maintainer --removable--bilateral, maxillary	21 and older		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	21 and older		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

Reimbursement includes local anesthesia. Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months. 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 are included as part of the restoration. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE IMPRESSION DATE. DO NOT BILL UNTIL DELIVERED.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		pre-operative x-ray(s)
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2740	crown - porcelain/ceramic	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2928) per 60 Month(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	21 and older	Teeth C - H, M - R	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	21 and older	Teeth A - T	No		
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No		

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2933	prefabricated stainless steel crown with resin window	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	21 and older	Teeth A - T	No		
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2941	Interim therapeutic restoration - primary dentition	21 and older	Teeth A - T	No	One of (D2941) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950) per 60 Month(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	Yes	Three of (D2951) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D2952	cast post and core in addition to crown	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2952) per 1 Day(s) Per patient per tooth.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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. 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 pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4910	periodontal maintenance procedures	21 and older		No	One of (D4910) per 12 Month(s) Per patient.	

Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem. A preformed denture with teeth already mounted forming a denture module is not a covered service. Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars). Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICSSHALL BE BASED ON THE CEMENTATION DATE.
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.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5211, D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5212, D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5211, D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5212, D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	21 and older		No		

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No		
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5750) per 36 Month(s) Per patient. One of (D5750) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of(D5130, D5140)	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5751) per 36 Month(s) Per patient. One of (D5751) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	One of (D5760) per 36 Month(s) Per patient. One of (D5760) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5761	reline mandibular partial denture (laboratory)	21 and older		No	One of (D5761) per 36 Month(s) Per patient. One of (D5761) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5899	unspecified removable prosthodontic procedure, by report	21 and older		Yes		

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

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity

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

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6096	remove broken implant retaining screw	21 and older	Teeth 1 - 32	Yes		narrative of medical necessity

Reimbursement includes local anesthesia and routine post-operative care. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. 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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7220) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7241) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7250) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7260	oroantral fistula closure	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	Yes		

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes		Pathology report
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D7471) per 1 Lifetime Per patient per arch.	pre-operative x-ray(s)
D7472	removal of torus palatinus	21 and older		Yes	One of (D7472) per 1 Lifetime Per patient.	pre-operative x-ray(s)
D7473	removal of torus mandibularis	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7473) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		Yes		narr. of med. necessity, post-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	21 and older		Yes		narr. of med. necessity, post-op x-ray(s)
D7899	unspecified TMD therapy, by report	21 and older		Yes		pre-operative x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7962	lingual frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7979	non-surgical sialolithotomy	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	21 and older		Yes		narrative of medical necessity

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9130	temporomandibular joint dysfunction--non-invasive physical therapies	21 and older		No		narrative of medical necessity
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Four of (D9223) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	Not allowed on same day as D9222, D9223, D9239, and D9243.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Four of (D9243) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9610	therapeutic drug injection, by report	21 and older		Yes	Three of (D9610, D9612) per 1 Day(s) Per patient.	narrative of medical necessity
D9612	therapeutic drug injection - 2 or more medications by report	21 and older		Yes	Three of (D9610, D9612) per 1 Day(s) Per patient.	narrative of medical necessity
D9613	infiltration of sustained release therapeutic drug--per quadrant	21 and older		Yes		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9945	occlusal guard--soft appliance full arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9946	occlusal guard--hard appliance, partial arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	

Exhibit A Benefits Covered for OH AmeriHealth Adult and ABD

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9961	duplicate/copy patient's records	21 and older		Yes		narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with D0140.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per patient. One of (D0120, D0150) per 6 Month(s) Per Provider.	
D0140	limited oral evaluation-problem focused	0-20		No		
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 60 Month(s) Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	One of (D0180) per 1 Year(s) Per patient. Not covered on same date of service as D0120 or D0150	
D0210	intraoral - comprehensive series of radiographic images	0-20		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No		
D0270	bitewing - single radiographic image	0-20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0273	bitewings - three radiographic images	10 - 20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per Provider OR Location.	
D0321	other temporomandibular joint films, by report	0-20		No		
D0330	panoramic radiographic image	0-20		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0340	cephalometric radiographic image	0-20		Yes	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		Yes	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-20		No	One of (D0210, D0330, D0367) per 60 Month(s) Per Provider OR Location.	
D0470	diagnostic casts	0-20		No	One of (D0340, D0350, D0470) per 12 Month(s) Per Provider OR Location.	
D0604	antigen testing for a public health related pathogen, including coronavirus	0-20		No		
D0605	antibody testing for a public health related pathogen, including coronavirus	0-20		No		

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

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

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1320	tobacco counseling for control and prevention of oral disease	0-20		No	Two of (D1320) per 12 Month(s) Per patient.	
D1321	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	0-20		No	Two of (D1321) per 12 Month(s) Per patient.	
D1351	sealant - per tooth	5 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 60 Month(s) Per Provider per tooth.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1354) per 1 Day(s) Per patient per tooth. Four of (D1354) per 1 Day(s) Per patient. Maximum four teeth per date of service.	
D1355	caries preventive medicament application – per tooth	0-20	Teeth 1 - 32, A - T	No	One of (D1355) per 1 Day(s) Per patient per tooth. Four of (D1355) per 1 Day(s) Per patient. Maximum four teeth per date of service.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	One of (D1707) per 1 Lifetime Per patient.	

Reimbursement includes local anesthesia. Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months. 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 are included as part of the restoration. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE IMPRESSION DATE. DO NOT BILL UNTIL DELIVERED.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2140	Amalgam - one surface, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2391	resin-based composite - one surface, posterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2392	resin-based composite - two surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2392	resin-based composite - two surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2394	resin-based composite - four or more surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 1 - 32	No	One of (D2928) per 60 Month(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth C - H, M - R	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-9	Teeth A - C, H - M, R - T	No		
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth 1 - 32	No		
D2930	prefabricated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	Yes		pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	Yes		pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	0-4	Teeth D - G, N - Q	No		

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	No		
D2933	prefabricated stainless steel crown with resin window	0-4	Teeth D - G, N - Q	No		
D2933	prefabricated stainless steel crown with resin window	0-9	Teeth A - C, H - M, R - T	No		
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth 1 - 32	No		
D2933	prefabricated stainless steel crown with resin window	5 - 20	Teeth D - G, N - Q	Yes		pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	10 - 20	Teeth A - C, H - M, R - T	Yes		pre-operative x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth 1 - 32	No		
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2941	Interim therapeutic restoration - primary dentition	0-20	Teeth A - T	No	One of (D2941) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	Yes	One of (D2951) per 12 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2952	cast post and core in addition to crown	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2952) per 1 Day(s) Per patient per tooth.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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. 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 pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4910	periodontal maintenance procedures	0-20		No	One of (D4910) per 12 Month(s) Per patient.	

Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem. A preformed denture with teeth already mounted forming a denture module is not a covered service. Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars). Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICSSHALL 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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-20		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	0-20		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	0-20		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5211, D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5212, D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5211, D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5212, D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	0-20		No		
D5512	repair broken complete denture base, maxillary	0-20		No		

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	0-20		No		
D5622	repair cast partial framework, maxillary	0-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No		
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 36 Month(s) Per patient. One of (D5750) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of(D5130, D5140)	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 36 Month(s) Per patient. One of (D5751) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 36 Month(s) Per patient. One of (D5760) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 36 Month(s) Per patient. One of (D5761) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5899	unspecified removable prosthodontic procedure, by report	0-20		Yes		

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

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

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

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6096	remove broken implant retaining screw	0-20	Teeth 1 - 32	Yes		narrative of medical necessity

Reimbursement includes local anesthesia and routine post-operative care. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. 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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-5	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6-10	Teeth A - C, H - M, R - T	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth D - G, N - Q	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	11 - 20	Teeth A - C, H - M, R - T	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7220) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7241) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7250) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7260	oroantral fistula closure	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	0-20		Yes		Pathology report
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
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)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
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)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D7471) per 1 Lifetime Per patient per arch.	pre-operative x-ray(s)
D7472	removal of torus palatinus	0-20		Yes	One of (D7472) per 1 Lifetime Per patient.	pre-operative x-ray(s)
D7473	removal of torus mandibularis	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7473) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes		narr. of med. necessity, post-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes		narr. of med. necessity, post-op x-ray(s)
D7899	unspecified TMD therapy, by report	0-20		Yes		pre-operative x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes		narrative of medical necessity
D7962	lingual frenectomy (frenulectomy)	0-20		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7979	non-surgical sialolithotomy	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

Coverage of comprehensive orthodontics is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient. Orthodontic service is considered to be medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Purely cosmetic orthodontic service is not covered. Coverage is further limited to children under age 21. Only one course of orthodontic treatment per recipient, per lifetime is covered.
D8670 periodic orthodontic treatment visit 21 and older would only be covered for a member whose comprehensive treatment had begun prior to age 21.
One per 90 Day(s) Per patient. Allowed as quarterly treatment visit. (D8670). May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090. Only payable to a dental provider with a specialty of Orthodontics. Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.
All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. The Member should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.
The ODMS 3630 Referral Evaluation Criteria Form is used as the basis for determining whether a Member qualifies for orthodontic treatment. Completed ODMS 3630 form and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member or face possible termination of their Provider agreement. Providers cannot bill prior to services being performed.
If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. DentaQuest will provide payment to the provider for the procedures submitted when requested (i.e. D0330, D0340, D0350, D0470).
General Billing Information for Orthodontics:
The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on this date of service. If a Member becomes ineligible during treatment and before full payment is made, it is the Member's responsibility to pay the balance for any remaining treatment. The Provider should notify the Member of this requirement prior to beginning treatment. To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:
Electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is 262. 241.7150. Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit claims for periodic treatment visits (Code D8670) and 2 units of retention (D8680). The member must be eligible on the date of the visit.
The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 8 quarters of periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 8 quarters will be the Provider's financial responsibility and not the Member's. Members may not be billed for broken, repaired, or replacement of brackets or wires. The Member must be eligible with their Health Plan in order for payments to be made. Whenever the Member becomes ineligible, the Member is responsible for payment during that time period.
Please notify DentaQuest should the Member discontinue treatment for any reason
Continuation of Treatment:
DentaQuest of Ohio, LLC requires the following information for possible payment of continuation of care cases:
DentaQuest LLC 115 of 116 April 29, 2022
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* Completed 'Orthodontic Continuation of Care Form'
* Completed ADA claim form listing services to be rendered.
* A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.
* A copy of the patient billing ledger

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

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient. Additional Documentation required: Ceph, Photos and Pano.	
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	One of (D8210) per 1 Lifetime Per patient. Complete images, diagnostic models, or photographs of the mouth. Additional Documentation.	narrative of medical necessity
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	Two of (D8220) per 1 Lifetime Per patient. Complete images, diagnostic models, or photographs of the mouth. Additional Documentation.	narrative of medical necessity
D8670	periodic orthodontic treatment visit	0-20		Yes	Seven of (D8670) per 1 Lifetime Per patient. One of (D8670) per 90 Day(s) Per patient.	
D8680	orthodontic retention (removal of appliances)	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D8680) per 1 Lifetime Per patient per arch.	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-20		Yes		narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	0-20		Yes	Debanding only.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9130	temporomandibular joint dysfunction--non-invasive physical therapies	0-20		No		narrative of medical necessity
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Four of (D9223) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		Yes	Not allowed on same day as D9222, D9223, D9239, and D9243.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Four of (D9243) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9610	therapeutic drug injection, by report	0-20		Yes	Three of (D9610, D9612) per 1 Day(s) Per patient.	narrative of medical necessity
D9612	therapeutic drug injection - 2 or more medications by report	0-20		Yes	Three of (D9610, D9612) per 1 Day(s) Per patient.	narrative of medical necessity
D9613	infiltration of sustained release therapeutic drug--per quadrant	0-20		Yes		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9946	occlusal guard--hard appliance, partial arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9961	duplicate/copy patient's records	0-20		No		narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Must be billed with D0140.	
D9999	unspecified adjunctive procedure, by report	0-20		Yes		pre-operative x-ray(s)