DentaQuest, LLC

Office Reference Manual

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

Blue Cross Complete of Michigan

Healthy Michigan Plan
Medicaid Adult 21+

PO Box 2906
Milwaukee, WI 53201-2906
844-870-3977
www.dentaquestgov.com

DentaQuest, LLC
Address and Telephone Numbers

Provider Services
PO Box 2906
Milwaukee, WI 53201-2906
844.870.3977

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
Medicaid Member Services: 844.583.6157
Provider Services: 844.870.3977

TDD (Hearing Impaired)
800.466.7566

Blue Cross Complete
Transportation Services
888.803.4947

Fraud Hotline
800.237.9139
or Anonymous Hotline: 866-737-3559
Visit: How to Report Fraud - DentaQuest

Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

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

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

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

- Via Fed Ex or other courier at street address:
  11100 W Liberty Drive
  Milwaukee, WI 53224
- Via Fax utilizing fax number: 262.834.3589

Medicaid State Plan

The Michigan Medicaid State Plan is an agreement between the State of Michigan and the federal government which identifies the general health care services, reimbursement of those services and the beneficiary and provider eligibility policies in effect under Michigan's Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services is the federal agency with oversight responsibility of the Medicaid Program. All parts, including updates or changes to the Plan, must be approved by CMS in order to become effective. Federal regulations detailing the State Plan purpose and maintenance procedures may be found at 42 CFR 430 Subpart B.

Please refer to the MDHHS Medicaid Provider Manual -Dental Chapter for Medicaid policies, covered dental services, coverage parameters, services that require prior authorization, billing instructions, etc. You may click on this link to access this manual:

MDHHS - Medicaid Provider Manual (michigan.gov) or visit **www.michigan.gov/mdhhs** and select it under Online Services located at the bottom of the landing page.

CHAMPS: Medicaid Enrollment Requirement:

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

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

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

To review instructions on this process:
-Visit www.michigan.gov/mdhhs -Select "Providers" from the left side menu, then the "Providers" link
-Click "CHAMPS" logo
-Scroll down to "Accessing the CHAMPS System" to find the "SSO Instructions" link

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

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

Cultural Competency Training Requirement

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

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

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

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

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

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

CMS provides a variety of online educational resources related to Medicaid compliance requirements and best practices to support dental offices in the fight against fraud, waste/error and abuse at: Medicaid Compliance for the Dental Professional | CMS

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

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

DentaQuest Fraud Hotline: 800.237.9139 or Anonymous hotline: 866-737-3559

DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906

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

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

1-855-MIFRAUD (643-7283) **or** www.michigan.gov/fraud

You can also visit MDHHS - (michigan.gov) to complete the **Medicaid Fraud and Abuse Online Complaint Form**.

The following information is preferred when reporting suspected fraud or abuse:

- Nature of the complaint
- The names of those involved in the suspected fraud and/or abuse, including their address, phone number, Medicaid identification number, date of birth (for beneficiaries), and any other identifying information if available/applicable

Blue Cross Complete of Michigan
Dental Appointment and Timely Access to Care Standards

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

DentaQuest, LLC

Statement of Members Rights and Responsibilities

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

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

2. All Members have a right to respectful and competent treatment regardless of race, color, religion, gender, sexual preference, veteran status, disability, or national origin.

3. All Members have the right to know the identity and professional status of all persons providing their oral health care services.

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

5. All Members have the right to be furnished dental care services in accordance with access and quality standards.

6. All Members have the right to fully participate in decisions concerning their dental care after receiving sufficient information to enable them to give informed consent before beginning any procedure and/or treatment.

7. All Members have the right to accept or refuse participation in research and educational projects affecting their care and/or treatment.

8. All Members have the right to refuse treatment, drugs or other procedures to the extent permitted by law and to be made aware of potential medical consequences of refusing treatment.

9. 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.

10. 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.

11. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request a second opinion or external review, including a State Fair Hearing.

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

13. All Members have the right to be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation.

14. All Members have a right to expect clean, safe, and accessible environment for receiving dental care services.

15. All Members have a right to have member literature and materials written in a manner that truthfully and accurately provides relevant information in a format that is readable and easily understood by the intended audience.

16. All Members have the right to have all records pertaining to dental care treated as confidential unless disclosure is necessary to interpret the application of the member's contract to dental care or unless disclosure is otherwise provided by law.

17. All Members have the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.524 and 45 CFR 164.526

18. All Members have the right to have their dentist advise and advocate on their behalf regarding dental care and treatment options, as well as the risks, benefits, and consequences of treatment or non-treatment

19. All Members have the right to be free to exercise all rights and that by exercising those rights, the Enrollee shall not be adversely treated by the Department, DentaQuest, and Participating Providers.

Likewise:

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

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

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

4. All Members have the responsibility of being considerate and cooperative in dealing with Plan staff.

5. All Members have the responsibility of scheduling appointments and arriving at their provider's office in time for scheduled visits. Members also have the responsibility to notify their provider's office within twenty-four (24) hours if they must cancel or will be late for a scheduled appointment.

6. All Members have the responsibility of designating an individual to act on their behalf and to authorize treatment in the event of incapacity.

7. All Members have the responsibility of reading and being aware of material distributed by the Plan explaining policies and procedures regarding services and benefits.

DentaQuest, LLC

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

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

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

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

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

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

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

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

8. Request copies of DentaQuest policies and procedures by contacting Provider Services at 844-876-7917.

Likewise:

1. All providers have the responsibility to be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of the member.

2. All the providers have the responsibility to understand and comply with obligations under Michigan Medicaid State or Federal laws and the Medicaid Provider Manual to assist members with skilled interpreters.

3. All providers have the responsibility to submit claims for services rendered to Blue Cross Complete Dental members. Providers must not balance bill, charge, collect deposit from, or seek any other compensation from members for covered services.

4. Participating practices are required to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, the "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists.

5. Providers shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. Per the Provider Agreement, provider must certify that no such excluded person will provide such services under the Agreement and no such excluded persons will

be employed by or utilized by any Downstream Entity with which Provider contracts relating to the furnishing of these services to Members. If Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider must immediately remove the Provider Related Party from any work related directly or indirectly to the Plan, and take all corrective actions required under applicable laws, rules or regulations.

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

DentaQuest, LLC

Member Confidentiality and Release of Information

As a reminder to all providers, information from members' medical records and from physicians or hospitals must be kept confidential in accordance with Federal and State law. Blue Cross Complete of Michigan recognizes that members have the right to have their health and medical information kept confidential, and we are committed to protecting access to our members' medical information. Blue Cross Complete of Michigan has defined confidential information in our policy as:

1. Clinical information communicated to a physician, or other health care provider, in his/her professional capacity, included in the medical record and directly related to a member's diagnosis and treatment.

2. Data included in the computer or system that is directly related to member's diagnosis and treatment, such as claims information, information collected in the course of Utilization/ Case Management or other processes.

3. Member-identifiable secondary health information abstracted from the medical records/ computer database for indexes and statistics.

4. Member information collected through the enrollment process or generated through Marketing.

A properly completed authorization signed by the member is required for release of all health information except:
- as required by Federal or State laws, court orders, or subpoenas
- for release to another health care provider currently involved in the care of the member
- as outline in the member's individual or group contract; and
- contractual obligations related to Quality Improvement or Utilization Management analysis.

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

- **Telephone inquiries.** Avoid disclosing confidential patient information over the telephone because you have no idea who you are actually speaking with. Anyone can **claim** to be a physician or the patient's relative. If you have the patient's permission to release the information, you should obtain identifying information (e.g. medical record number, address, date of birth, etc.) before giving out any information over the telephone.

- **Phone messages to a patient's home or place of employment.** Leaving messages containing health information with another person or on an answering machine at the patient's home or at work may violate the patient's privacy, unless he/she has authorized you to do so. Leave your name, phone number and place of employment and ask the patient to return your call. If you know that you will need to call the patient back with advice or test results later in the day, ask the patient if you can leave a message on their answering machine or with another member of their family in the event they are not available. Document they gave you verbal consent to do so.

- **Reporting test results by mail.** All correspondence that contains health information (e.g. test results, appointment reminders) should be mailed to patients in a sealed envelope or post card that can be sealed in some manner.

- **Conversations in social settings.** Be aware of your surroundings. A patient's neighbor, relative or colleague may be in the elevator with you, sitting next to you at lunch, or following you out the door as you leave the office.

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

* * *

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

Office Reference Manual

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

a) DentaQuest policies and procedures, grievances, appeals, and fair hearing procedures and timeframes, claims filing, benefits and limitations, prior authorizations, orthodontic criteria, EPSDT services, and other topics including pertinent addresses and telephone numbers for additional assistance, as applicable and/or required by client, product, or Health Plan.

b) The ORM is made available to prospective practitioners during recruitment efforts and at the time of contracting by providing a link to the most up to date version of the ORM online

c) The ORM assists practitioners in running an efficient office and keeps offices informed of changes that may occur from time to time.

d) Material changes to the content of the ORM are communicated to participating network providers by the Provider Engagement team as necessary or required by statutory, regulatory, or contractual obligations.

e) The ORM is updated on an annual basis or periodically throughout the year based on updates where applicable.

f) The ORM is accessible to DentaQuest Customer Service Representatives and other appropriate staff to serve as a tool and assist with network provider questions as needed.

Provider Engagement Representatives

DentaQuest has found that personalized service is critical to assist provider offices with more specialized network or plan questions and escalated issues. Thus, our Provider Engagement representatives are available during normal business hours and will respond to voicemails, e-mails, and mail within one business day. To find out who is the assigned territory Provider Engagement representative for your office location, call Prover Services at 844.870.3977.

A full list of covered codes for Blue Cross Complete can be viewed in Exhibit A .

Office Reference Manual
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Additional Resources

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

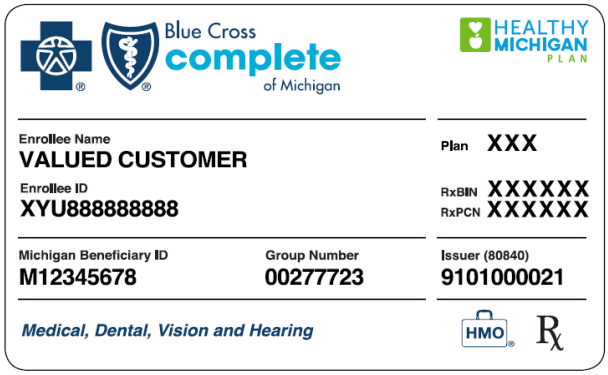
Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

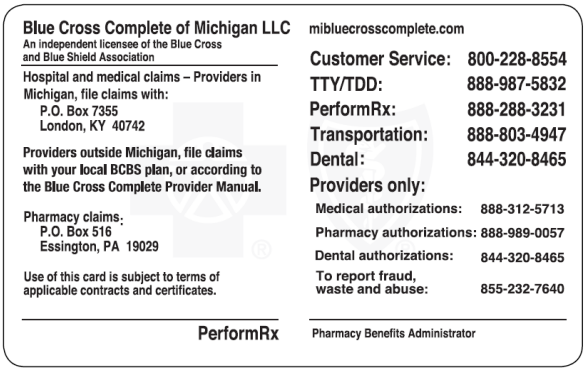
Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Members will receive a Plan ID Card.

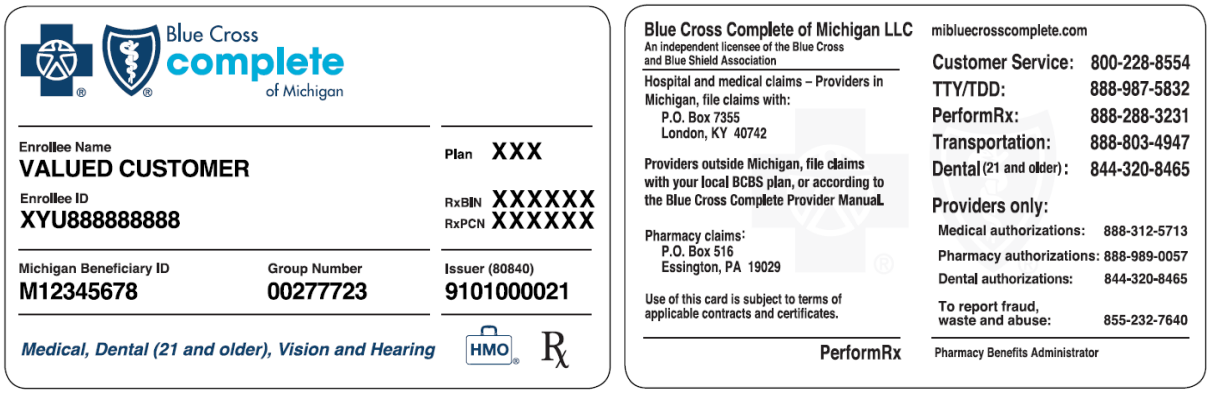
DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the Health Plan identification card is not dated and it does not need to be returned to the Health Plan should a Member lose eligibility. Therefore,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

Sample of Healthy Michigan Plan card:





Sample of standard Medicaid 21+ ID card:



Note: Members turning 21 (aging into benefits) will receive the standard Medicaid ID card

1.03 DentaQuest Eligibility Systems

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

Access to eligibility information via the Internet
DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 800-341-8478. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line
To access the IVR, simply call DentaQuest's Customer Service Department at 855.398.8411 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid 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 800-341-8478.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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 844-870-3977. They will be able to assist you in utilizing either system.

1.04 State Eligibility System

Michigan Department of Job and Family Services
313-372-6200

1.05 Health Plan Eligibility Phone Number

Health Plan
1-844-320-8465 (TTY: **711**)

1.06 Specialist Referral Process

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

1.07 Out of Network Process

Blue Cross Complete members must get services from dental providers within our network. These providers have met specific credentialing criteria. Services provided by an out-of-network provider are allowed in some cases such as when the appropriate plan dental provider is not readily available or when services cannot be obtained within a reasonable distance and timely basis. All requests for out-of-network services require prior authorization.

Members and/or providers requesting prior authorization of care by an out-of-network provider should contact DentaQuest at 844-822-8112 for assistance.

1.08 Transportation

Blue Cross Complete provides options for routine transportation to and from dental provider offices. Members can also get paid back for gas when they drive to and from office visits. Non-emergency transportation is covered for Healthy Michigan Plan and pregnant women going back and forth for these visits. Call Blue Cross Complete transportation – Medicaid members **1-888-803-4947**. TTY users should call **711** for regularly scheduled appointments at least three calendar days before your scheduled appointments to talk through options. For trips that require mileage reimbursement for Dual members, enrollees must contact Blue Cross Complete at least 72 hours in advance for non-urgent trips

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 treatment begins (Non-emergency) treatment.

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

Your submission of "documentation" should include:

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

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

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

B. Submitting Authorization Requests and X-Rays

- Electronic submission using the 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.

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 Covered and Non-Covered Services

Plan Reimbursement Policy:

(a) Compensation of Participating Practice by DentaQuest is subject to, and dependent upon, DentaQuest's receipt of proper claims payment from Plan. In the event of nonpayment by Plan, DentaQuest reserves the right to withhold or recover payment to Participating Practice for all claims not paid by Plan. If and when DentaQuest has received the outstanding amount for such claims from Plan, DentaQuest will reimburse Participating Practice according to the terms of the Provider Agreement.
(b) Fee Schedule. Participating Practice shall be compensated in accordance with the applicable fee schedule that corresponds to plan/product type.
(c) Continuation of care: Participating Practice agrees to complete any treatment in progress for continuation of care cases and cases in mid-treatment for a newly enrolled member. DentaQuest agrees to negotiate fees in good faith for partial cases/treatments.
(d) Hold Harmless: 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, LLC
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

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.

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

Health Plan: 888-437-0606, TTY 800-649-3777

For a current listing of participating hospitals, please contact the plan.

4.00 Claim Submission Procedures (claim filing options)

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

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

4.01 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 log on to www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 855.398.8411. Once logged in, select “Claims/Pre-Authorizations” and then “Dental Claim Entry“. The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Customer Service Department at 844.870.3977.

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 website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 844-870-3977. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

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

4.04 Electronic Claim Submission via Clearinghouse

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

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

4.05 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@dentaquest.com to inquire about this option for electronic claim submission.

4.06 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance

with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

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) 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, LLC-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

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

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

<u>Overpayment of Claims</u>

A provider who receives an overpayment must self-identify and report the overpayment to DentaQuest immediately upon identification of having received an overpayment.

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

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 Email – standardupdates@dentaquest.com
    - Via Mail – DentaQuest, LLC.
      PO Box 2906
      Milwaukee, WI 53201-2906
      ATTN: Standard Updates

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 www.dentaquest.com
2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

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

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

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

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

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

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

5.01 Use of Provider Information

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

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 855.398.8411 or via e-mail at denelig.benefits@dentaquest.com.

5.02 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, Appeals and Grievances

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

DentaQuest in conjunction with the health plan has established a member grievance process that shall guarantee any member the right for a review when they are dissatisfied with a service/benefit. The member is informed that they may request a State Fair Hearing for appeals, which may be filed simultaneously as the DentaQuest or health plan appeal. Members will receive assistance, if required, to file either a grievance or an appeal.

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

Members also have the right to request and receive a written copy of DentaQuest's utilization management criteria in cases where the appeal is related to a clinical decision/denial or other applicable health plan policies or procedures relevant to the decision or action that is the subject of the appeal. These can be requested by contacting Customer Service at 888.307.6547 or via e-mail at denclaims@dentaquest.com.

DentaQuest adheres to State, Federal, and Plan requirements related to processing inquiries, grievances and appeals. Enrollees have the right to request continuation of benefits while utilizing the grievance system. Unless otherwise required by Agency and Plan, DentaQuest's processes such inquires, grievances and appeals consistent with the following:

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

Grievance: Any dispute, other than one that constitutes an organization determination or an Appeal of an Adverse Action expressing dissatisfaction with any aspect of Blue Cross Complete's or DentaQuest's operations, activities, or behavior, regardless of whether remedial action is requested.

Providers have the right to submit a grievance verbally or in writing to DentaQuest. You have 60 calendar days from the date of the determination to file the grievance. All documentation relating to the grievance should be included in the submission.

All **provide**r grievances should be sent to:

DentaQuest
Attn: Provider Grievance,
PO Box 2906
Milwaukee, WI 53201-2906

DentaQuest will respond to the grievance no later than 35 days after we receive the request with any necessary supporting documentation.

All **member** grievance must be sent to:

Member Grievances
Blue Cross Complete
P.O. Box 41789

North Charleston, SC 29423

If you need assistance with filing a member grievance, call Customer Service at:
1-800-228-8554 TTY: 1-888-987-5832
Available 24 hours a day, seven days a week

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

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

Pre-Service Appeals: If you or the member disagrees with DentaQuest's decision concerning a pre-service request, you or the member may file an appeal verbally or in writing. If you are appealing on the member's behalf you must include their written permission with your request. You have 60 days to file a pre-service appeal. Member appeals will be resolved within thirty (30) calendar days.

All pre-service appeals should be sent to:
Blue Cross Complete
P.O Box 41789
North Charleston, SC 29423
1-800-228-8554 TTY: 1-888-987-5832

Post-Service Appeal: If you or the member disagrees with DentaQuest's decision concerning a post-service request, you or the member can file an appeal in writing. You have 60 calendar days from the date of determination to file the appeal.

All post-service appeals should be sent to:
DentaQuest,
Attn: Provider Appeals,
PO Box 2906
Milwaukee, WI 53201-2906

DentaQuest will respond to the appeal no later than 30 days after we receive the request with any necessary supporting documentation.

Expedited Appeals: When a service has been delayed, denied, reduced or terminated, the member or their authorized representative can request verbally or in writing a request for review and reconsideration of an action in an urgent or expedited timeframe, if he/she feels the normal timeframe of the appeal procedure would seriously jeopardize their life or dental health or ability to attain, maintain, or regain maximum function. An expedited appeal cannot be requested when

the service(s) has already been rendered. Provider requests for an expedited appeal are considered member appeals and subject to member appeal timeframes and policies.

Expedited requests are available for circumstances when waiting would seriously jeopardize the well-being of the member. A verbal request indicating the need for an expedited review should be made directly to Blue Cross Complete. Those requests for an expedited review that meet the above criteria will have the determinations made within seventy-two (72) hours.

All expedited appeals should be directed to:

Blue Cross Complete
P.O Box 41789
North Charleston, SC 29423
1-800-228-8554 TTY: 1-888-987-5832
Urgent Review Fax: 1-866-900-4482

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 844-870-3977.

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 particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

7.02 Community Practice Patterns

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

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

7.03 Evaluation

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

- Diagnostic and preventive treatment;

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

7.04 Results

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

7.05 Fraud, Prevention and Recovery

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

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

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

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

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

FRAUD

- Filing a claim for a service not provided
- Falsifying information on a claim form in attempt to gain benefits
  - Procedure performed
  - Treating dentist
  - Tooth, quadrant, surface treated
  - Date of service
  - Location of service
- Altering a claim, diagnosis and/or other records

  - Resubmitting a claim with a modified/altered date of service to maximize benefits and/or circumvent a time limitation
- Billing non-covered services as covered services
  - Billing for a four or more surface anterior composite restoration when documentation supports an indirect composite veneer was performed
- Using someone else's identification card

ABUSE

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

WASTE/ERROR

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

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

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

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

Pretreatment estimates issued by DentaQuest are not a guarantee of payment. DentaQuest reserves the right to recover dollars for procedures that no longer qualify for the pre-approved estimate of payment; reasons may include lack of dental necessity, do

not meet the standards of good dental practice and/or are unsupported in the member's treatment record.

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

False Claims Act

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

Federal False Claims Act (FCA)

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

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

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

State False Claims Acts

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

Whistleblower Protection

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

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 844.870.3977 or via e-mail at:

denelig.benefits@dentaquest.com

9.00 Credentialing (Policies 300 Series)

Policy: It is Company policy to ensure that individuals providing services to and performing care on members enrolled in a health plan offered or administered by the Company are appropriately licensed professionals and adhere to the highest quality of care and ethical standards. Through the collection and verifications of primary source documentation and nationally recognized accreditation standards for health care credentialing, DentaQuest ensures that its network providers meet or exceed CMS guidelines, NCQA & URAC provider credentialing standards, and state or health plan client requirements.

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

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.

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)

Procedures for Discipline and Termination (Policies 300.017-300.025)

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 36 months.

If you have credentialing questions, or would like a copy of the aforementioned policies, please contact DentaQuest's Credentialing Hotline at 800.233.1648 or via e-mail at:

denelig.benefits@dentaquest.com

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.
c. Type and dosage of anesthetics and medications given or prescribed.
d. Localization of procedure/observation. (tooth #, quadrant etc.)
e. Signature of the Provider who rendered the service.

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

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

C. Compliance

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

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.

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

Type of Care/Appointment	Length of Wait Time
Emergency Dental Services	Immediately 24 hours/day 7 Days per week
Urgent Dental Care	Within 48 hours
Routine Dental Care	Within twenty-one (21) Business Days of request
Preventive Dental Services	Within six (6) weeks of request
Initial Dental Appointment	Within eight (8) weeks of request

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 periapicals with posterior bitewings for a new adolescent patient.

4. Adult – dentulous

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

5. Adult – edentulous

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

B. Radiographic Examination of the Recall Patient

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

   a. Child – primary and transitional dentition

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

increased risk for the development of caries in either the primary or transitional dentition.

b. Adolescent

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

c. Adult – dentulous

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

d. Adult – edentulous

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

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

a. Child – primary dentition

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

b. Adolescent

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

c. Adult – dentulous

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

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

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

4. Growth and Development Assessment

a. Child – Primary Dentition

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

b. Child – Transitional Dentition

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

c. Adolescent

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

d. Adult

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

14.00 Clinical Criteria

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

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

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

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

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

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

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

Criteria

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

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

- Alveoloplasty (code D7310) in conjunction with four or more extractions in the same quadrant will be covered subject to consultant review.

14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

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

Criteria

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

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

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

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

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

- Request should include a dated post-endodontic radiograph.

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

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

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

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

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

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

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay.
- An existing crown is present with chipped or fractured porcelain without decay.

14.03 Criteria for Stainless Steel Crowns

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

Documentation needed for authorization of procedure:

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

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

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

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

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

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

Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay.
- An existing crown is present with chipped or fractured porcelain without decay.

14.04 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

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

<u>All Operating Room (OR) Cases Must be Authorized.</u>

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should contact Blue Cross Complete for facility authorization by one of the following options:

- Provider Medical Authorization Portal - www.navinet.net [navinet.net] (preferred)
- By phone: 1-888-312-5713 (press 1 then 4)

- Fax clinical documentation for authorizations to 1-888-989-0019

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.

14.05 Criteria for Fixed Prosthodontics

Documentation needed for authorization of procedure:

- Detailed Treatment plan.

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

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

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

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.

- The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.
- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- Fixed partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type 1 or 2), and a favorable prognosis where continuous deterioration is not expected.
- As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

Authorizations for prosthesis will not meet criteria:

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If abutment teeth are less than 50% supported in bone.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.
- Without a documented physical or neurological disorder. Claim of gagging is not sufficient to qualify for a fixed prosthesis.

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

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

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

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.

- 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.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures); it must be at least 5 years old and unserviceable to qualify for replacement.

Approval for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. Approval for cast partial dentures for anterior teeth **generally** will not be given unless one or more anterior teeth in the same arch are missing. (MDHHS removed the requirement for missing at least one anterior tooth 4.1.23)

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If there are 8 or more posterior teeth in occlusion. (MDHHS removed this requirement 4.1.23)
- 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 the recipient does not have a good attendance record.

- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.

- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Benefit Limits

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.

- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:

    - Adjustments will be reimbursed at one per calendar year per denture.

    - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.

    - Relines will be reimbursed once per denture every 36 months.

- A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.

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

- Preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) are not a covered benefit.

- The fee for complete and partial dentures includes six months of post-insertion follow-up care including adjustments, repairs and relines.

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

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

14.07 Criteria for the Excision of Bone Tissue

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

Code D7471 (CDT–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, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

14.08 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

14.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

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

Criteria

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

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.

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

And/or one of the following medical conditions:

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

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization.
Documentation needed for authorization of any periodontal procedures:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan
- Narrative of medical necessity

Periodontal scaling and root planing (D4341), 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) affected teeth 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.

- Other periodontal procedures will be reviewed for medical necessity and appropriateness of care according to the ADA definitions of code terminology.

APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

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

- **an employer, directly or on behalf of the State of Michigan, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");**
- **a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Michigan or its regulatory agencies or Plan and DentaQuest (a "Medicaid Contract");**

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

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

C. "DentaQuest" shall refer to DentaQuest, LLC

D. "DentaQuest Service Area" shall be defined as the State of Michigan.

E. "Medically Necessary" means a service or benefit is medically necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- **The Service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.**
- **The service or benefit will, or is reasonably expected to, reduce or ameliorate, the physical, mental, or developmental effects of an illness, condition, injury or disability.**
- **The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.**

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

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

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

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

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

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

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ 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 User ID. Once logged in, select the link “Related Documents” to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Electronic Funds Transfer Form
- Medical and Dental History
- 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:

DentaQuest Provider Services: 844-870-3977

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

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

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

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

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

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

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
	44. Date of Prior Placement (MM/DD/CCYY)

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

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

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

To reorder call 800.947.4746

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

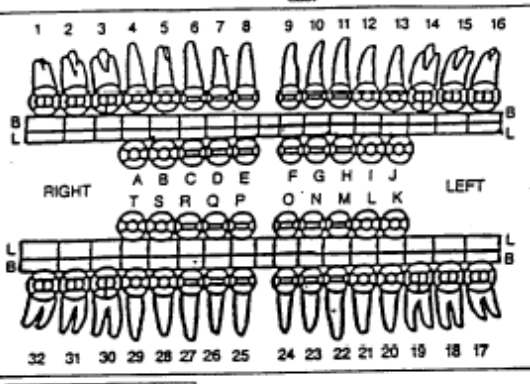
Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

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

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY_____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

_____

_____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY_____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

_____

_____

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

Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

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

INSTRUCTIONS

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

MAINTENANCE TYPE:

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

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____ Checking

_____ Personal _____ Business (choose one)

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

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

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

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

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

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

_____ _____
Date Print Name

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

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

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

MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

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

If yes, please list: _____

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

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

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

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

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

Are you on a special diet? □ Yes □ No

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

If yes, please list: _____

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

Heart Disease or Attack	□ Yes	□ No	Stroke	□ Yes	□ No	Hepatitis C	□ Yes	□ No
Heart Failure	□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Arteriosclerosis (hardening of 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

Request for Transfer of Records

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

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

Please have these records sent to:

_____

_____

_____

Signed: _____ Date: _____
(Patient)

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

Address: _____

Address: _____

Phone: _____

Agreement to Pay Non-Covered Services

Patient Name: _____

Recipient (Medicaid) ID: _____

Guarantor Name: _____

Relationship to Patient: _____

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

Non-Covered Services

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

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

_____ _____

Guarantor Signature Date

Guarantor Address: *Guarantor Phone:*

_____ Home: _____

Street, Apt #

Cell: _____

_____ Work:

_____

City, State, Zip

DentaQuest, LLC.
837 Dental Companion Guide

1.0 Introduction

Section 1.1 What Is HIPAA?

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

Additional HIPAA Requirements

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

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

Section 1.2 Purpose of the Implementation Guide

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

Section 1.3 How to Obtain Copies of the Implementation Guides

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

Section 1.4 Purpose of this Companion Guide

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

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

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

Section 1.5 Intended Audience

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

Section 1.6 Introduction to the 837 Dental Healthcare Claims Transaction

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

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

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

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

Dental Transaction ASC X12N 837(004010X097A1)

2.0 Trading Partners

Section 2.1 General Overview

All entities desiring to be a Trading Partner must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile Form for each business entity. To obtain the TPA and Profile Form please contact Provider Services at 1-844-870-3977. Please note that the profile information may be given over the telephone in lieu of completing a paper form. DentaQuest will assign a Trading Partner ID for your use in electronic transaction exchange and login into DentaQuest's Trading Partner Web Portal.

Section 2.2 Establishing Connectivity

DentaQuest will maintain various methods of exchanging EDI information. DentaQuest has created a Trading Partner Web Portal to allow trading partners to exchange Dental Claim transactions and this is the preferred method of facilitating EDI exchange. The portal allows a Trading Partner to submit and receive transactions. Outgoing transmissions, including all response transactions and functional acknowledgments will be available only through the Trading Partner Web Portal. Other Trading Partner submission methods include SSL FTP. Contact Provider Services at 1-844-870-3977 with questions about these options.

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

Section 2.3 Trading Partner Testing

Prior to submitting production 837D claims, the Trading Partner must complete testing. Testing includes HIPAA compliance as well as validating the use of conditional, optional and mutually defined components of the transaction. Contact Provider Services at 1-844-870-3977 to discuss the transmission method, testing process and criteria.

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

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

3.0 Technical Requirements

Section 3.1 File Size

For 837D transactions, DentaQuest is imposing a limit of 50,000 claim transactions per submission. If you have any questions or would like to coordinate the processing of larger files, please contact Provider Services at 1-844-870-3977.

Section 3.2 Naming Convention

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

Naming Convention: **P837D_20001_20061010_001**
P – indicates whether this is a production or test (**T**) file
837D – indicates the transaction type
200001 – indicates the 6 digit trading partner ID
20061023 – indicates the date the file was sent (YYYYMMDD)
001 – indicates the sequence number of the file, incremented for subsequent submissions on the same day

Section 3.3 Multiple Transactions Types In a File

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

Section 3.4 Balancing Data Elements

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

4.0 Acknowledgments

Section 4.1 Functional Acknowledgment Transaction Set (997)

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

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

5.0 Support Contact Information

DentaQuest Provider Service phone number: 1-844.870.3977.

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Email: eclaims@DentaQuest.com

6.0 SPECIFIC DATA REQUIREMENTS

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

Section 6.1 Claim Attachments

An electronic standard for claim attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, DentaQuest has an alternative method for handling electronic claims that require attachments. If you are enrolled and are using the service offered by National Electronic Attachments (NEA), DentaQuest can accept the assigned NEA control/tracking number when reported in the notes segment (NTE segment). For more information about using NEA to submit electronic attachments contact Customer Service at 1-800-207-5019 or you may contact NEA directly at www.nea-fast.com or 1-800-782-5150.

Section 6.2 Predeterminations

DentaQuest will not accept Predetermination of Benefits Claims.

Section 6.3 Coordination of Benefits (COB) Claims

Submit by paper with primary carrier explanation of benefits attached.

Section 6.4 Void Transactions

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

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

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

Section 6.5 Detail Data

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

6.5.01 Control Segments

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

6.5.02 ISA – Interchange Control Header segment

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

6.5.03 IEA – Interchange Control Trailer

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

6.5.04 GS-Functional Group Header

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

6.5.05 GE-Functional Group Trailer

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

6.5.06 Preferred Delimiters

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

6.5.07 Segment Definitions

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

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

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

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

ST - Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of

the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

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

6.5.08 837 Dental Healthcare Claim Transaction

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

Field Definition
Column

A The name of the loop as documented in the appropriate 837 Implementation Guide.
B Loop ID used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837 Implementation Guide.
C The field position number and segment number as specified in the appropriate 837 Implementation Guide.
D The data element name and page number as indicated in the appropriate 837 Implementation Guide.
E The Values and Comments further describe the appropriate 837 Implementation Guide Field data that DentaQuest will accept for processing a claim.

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

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

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

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

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

7.0 APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

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

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org

Association for Electronic Health Care Transactions (AFEHCT)

- A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

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

- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. http://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the

Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

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

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:

844-870-3977

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 or not the service is subject to prior authorization, any other applicable benefit limitations.**

DentaQuest Prior Authorization & Pre-Payment Process

IMPORTANT

For procedures where "Prior Authorization Required" or "Pre-Payment Review 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 prior to treatment:

"Prior 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:"

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

PLEASE NOTE

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

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

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.
All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	19 and older		No	No	One of (D0120, D0150) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	19 and older		No	No	Two of (D0140) per 1 Month(s) Per patient. May be used for Tele-dentistry visit; bill with POS 2. Not allowed with any service other than radiographs and simple or surgical extractions.	
D0150	comprehensive oral evaluation - new or established patient	19 and older		No	No	One of (D0120, D0150) per 6 Month(s) Per patient. One of (D0150) per 36 Month(s) Per Provider.	
D0180	comprehensive periodontal evaluation - new or established patient	19 and older		No	No	One of (D0180) per 12 Month(s) Per Provider OR Location.	
D0191	Assessment of a patient	19 and older		No	No	One of (D0120, D0150, D0190, D0191) per 6 Month(s) Per Provider.	
D0210	intraoral - comprehensive series of radiographic images	19 and older		No	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	19 and older		No	No		
D0230	intraoral - periapical each additional radiographic image	19 and older		No	No		
D0240	intraoral - occlusal radiographic image	19-20		No	No	Two of (D0240) per 36 Month(s) Per patient.	

Exhibit A Benefits Covered for
Healthy Michigan Plan and Medicaid Adult 21+

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	19 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images	19 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewings - three radiographic images	19 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	19 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0330	panoramic radiographic image	19 and older		No	No	One of (D0210, D0330, D0372, D0387) per 60 Month(s) Per patient.	
D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum	19 and older		No	No	One of (D0600) per 6 Month(s) Per Provider.	
D0601	Caries risk assessment and documentation, with a finding of low risk	19 and older		No	No	One of (D0601, D0602, D0603) per 6 Month(s) Per Provider.	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	19 and older		No	No	One of (D0601, D0602, D0603) per 6 Month(s) Per Provider.	
D0603	Caries risk assessment and documentation, with a finding of high risk	19 and older		No	No	One of (D0601, D0602, D0603) per 6 Month(s) Per patient.	

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.
Space maintainers are a covered service when indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance.
BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.

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

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	19 and older		No	No	One of (D1110) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish	19-21		No	No	One of (D1206) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	19-21		No	No	One of (D1208) per 6 Month(s) Per patient.	
D1351	sealant - per tooth	19 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	No	One of (D1351, D1352) per 36 Month(s) Per patient per tooth.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	19 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	No	One of (D1351, D1352) per 36 Month(s) Per patient per tooth.	
D1354	application of caries arresting medicament- per tooth	19 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	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	

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It is DentaQuest's expectation that the Primary Care Dentist (PCD) provide basic and advanced dental services to their patients. However, DentaQuest understands that certain procedures may fall beyond the scope or comfort level of the PCD. To avoid the need for a cumbersome referral process, DentaQuest is leaving the entire process in the hands of the providers. However, DentaQuest's Utilization Management department will continually monitor provider referral patterns to assure appropriate placement of patients and allocation of funds.
Reimbursement includes local anesthesia.
Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least (36) thirty-six months, unless there is recurrent decay or material failure.
Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.
Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing and pulp capping are included as part of the restoration.
Restoration of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable.
As a condition for payment, it may be necessary to submit, upon request, radiographs and other information to support the appropriateness and necessity of these restorations.
Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible, or for a molar tooth in those patients age 21 and over which has been endodontically treated without prior approval from DentaQuest. Also, crowns will not be routinely approved when there are eight natural or prosthetic bicuspids and/or molars (four maxillary and four mandibular teeth) in functional contact with each other.
Crowns will not be routinely approved when functional replacement of tooth contour with other restorative materials is possible, or for a posterior tooth which has been endodontically treated without prior approval from DentaQuest.
BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER PROSTHETIC SHALL BE BASED ON THE CEMENTATION DATE.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

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

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per Provider per tooth, per surface.	
D2710	crown - resin-based composite (indirect)	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2712	crown - 3/4 resin-based composite (indirect)	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2750	crown - porcelain fused to high noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2780	crown - ¾ cast high noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2781	crown - ¾ cast predominantly base metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2782	crown - ¾ cast noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2783	crown - ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2794	Crown- Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	19 and older	Teeth 1 - 32	No	No	One of (D2910) per 6 Month(s) Per patient per tooth.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	19 and older	Teeth 1 - 32	No	No	One of (D2915) per 6 Month(s) Per patient per tooth.	
D2920	re-cement or re-bond crown	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2920) per 6 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	19 and older	Teeth A - T	No	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	

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Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated stainless steel crown-permanent tooth	19 and older	Teeth 1 - 32	No	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	19 and older	Teeth A - T	No	No	One of (D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2940	protective restoration	19 and older	Teeth 1 - 32, A - T	No	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	19 and older	Teeth 1 - 32	No	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth. Must meet criteria for full crown coverage.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	19 and older	Teeth 1 - 32	No	No	One of (D2951) per 24 Month(s) Per patient per tooth.	
D2952	cast post and core in addition to crown	19 and older	Teeth 1 - 32	No	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth. Must meet criteria for full crown coverage.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	19 and older	Teeth 1 - 32	No	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth. Must meet criteria for full crown coverage.	pre-operative x-ray(s)
D2999	unspecified restorative procedure, by report	19 and older	Teeth 1 - 32, A - T	Yes	No	Use D2999 for incomplete crown:-Date of service is the date of the impression.-Provide the reason treatment was not completed.-Submit an itemized statement of the invoice detailing the laboratory costs.	Lab bills

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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.
A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.
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 all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative and fill radiographs.
Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.
Eight posterior natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests for endodontic therapy will be reviewed for necessity based upon the presence/absence of eight points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).
Provision of root canal therapy is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Root canal therapy will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment, or unless its replacement by addition to an existing prosthesis is not feasible. If the total number of teeth which require, or are likely to require, root canal therapy or apical surgery would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the patient, treatment will not be covered. Pulp capping is not reimbursable.

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

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (exluding final restoration)	19-20	Teeth 1 - 32, A - T	No	No	One of (D3110) per 1 Lifetime Per patient per tooth.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	19-20	Teeth 1 - 32	No	No	One of (D3222) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth.	

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Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3347	retreatment of previous root canal therapy - premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	
D3348	retreatment of previous root canal therapy-molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth.	
D3410	apicoectomy - anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth.	
D3421	apicoectomy - premolar (first root)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth.	
D3425	apicoectomy - molar (first root)	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3425) per 1 Lifetime Per patient per tooth.	
D3426	apicoectomy (each additional root)	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D3426) per 1 Lifetime Per patient per tooth.	
D3430	retrograde filling - per root	19 and older	Teeth 1 - 32	No	No	One of (D3430) per 1 Lifetime Per patient per tooth.	
D3999	unspecified endodontic procedure, by report	19 and older	Teeth 1 - 32, A - T	Yes	No	Use D3999 For incomplete root canal.-Date of service is date of the first tx appointment.-Provide reason tx was not completed.	narrative of medical necessity

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

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Not to exceed 2 quads (D4341, D4342) per date of service.	Full mouth xrays & perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Not to exceed 2 quads (D4341, D4342) per date of service.	Full mouth xrays & perio charting
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	19 and older		No	No	One of (D4346) per 6 Month(s) Per patient. Not covered when billed on same date of service or within 6 month(s) of (D1110, D4341, D4342, D4355, D4910)	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	19 and older		No	No	One of (D4355) per 12 Month(s) Per patient. Not allowed on same DOS as D0180 or D1110.	
D4910	periodontal maintenance procedures	19 and older		No	No	One of (D4910) per 6 Month(s) Per patient. Not covered when billed in conjunction with (D1110, D4341, D4342, D4346, D4355) on the same date of service.	

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A preformed denture with teeth already mounted forming a denture module is not a covered service.
Complete and/or partial dentures will be approved only when existing prostheses are not serviceable or cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch.
Dentures which are lost, stolen, or broken will not be replaced.
BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER PROSTHETIC SHALL BE BASED ON THE CEMENTATION DATE.

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

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5120	complete denture - mandibular	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5130	immediate denture - maxillary	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5140	immediate denture - mandibular	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5225	maxillary partial denture-flexible base	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient.	
D5226	mandibular partial denture-flexible base	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient.	
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	19 and older		No	No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227) per 60 Month(s) Per patient.	
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	19 and older		No	No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228) per 60 Month(s) Per patient.	
D5410	adjust complete denture - maxillary	19 and older		No	No	One of (D5410) per 6 Month(s) Per patient. not allowed within 6 months of delivery	
D5411	adjust complete denture - mandibular	19 and older		No	No	One of (D5411) per 6 Month(s) Per patient. not allowed within 6 months of delivery	
D5421	adjust partial denture-maxillary	19 and older		No	No	One of (D5421) per 6 Month(s) Per patient. not allowed within 6 months of delivery	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5422	adjust partial denture - mandibular	19 and older		No	No	One of (D5422) per 6 Month(s) Per patient. not allowed within 6 months of delivery	
D5511	repair broken complete denture base, mandibular	19 and older		No	No		
D5512	repair broken complete denture base, maxillary	19 and older		No	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	19 and older	Teeth 1 - 32	No	No		
D5611	repair resin partial denture base, mandibular	19 and older		No	No		
D5612	repair resin partial denture base, maxillary	19 and older		No	No		
D5621	repair cast partial framework, mandibular	19 and older		No	No		
D5622	repair cast partial framework, maxillary	19 and older		No	No		
D5630	repair or replace broken retentive/clasping materials per tooth	19 and older	Teeth 1 - 32	No	No		
D5640	replace broken teeth-per tooth	19 and older	Teeth 1 - 32	No	No		
D5650	add tooth to existing partial denture	19 and older	Teeth 1 - 32	No	No	Two of (D5650) per 12 Month(s) Per patient.	
D5660	add clasp to existing partial denture	19 and older	Teeth 1 - 32	No	No		
D5710	rebase complete maxillary denture	19 and older		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient per arch.	
D5711	rebase complete mandibular denture	19 and older		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient per arch.	
D5720	rebase maxillary partial denture	19 and older		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient per arch.	
D5721	rebase mandibular partial denture	19 and older		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient per arch.	
D5725	rebase hybrid prosthesis	19 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D5725) per 24 Month(s) Per patient per arch.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5730	reline complete maxillary denture (chairside)	19 and older		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient per arch.	
D5731	reline complete mandibular denture (chairside)	19 and older		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient per arch.	
D5740	reline maxillary partial denture (chairside)	19 and older		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient per arch.	
D5741	reline mandibular partial denture (chairside)	19 and older		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient per arch.	
D5750	reline complete maxillary denture (laboratory)	19 and older		No	No	One of (D5710, D5730, D5750) per 24 Month(s) Per patient per arch.	
D5751	reline complete mandibular denture (laboratory)	19 and older		No	No	One of (D5711, D5731, D5751) per 24 Month(s) Per patient per arch.	
D5760	reline maxillary partial denture (laboratory)	19 and older		No	No	One of (D5720, D5740, D5760) per 24 Month(s) Per patient per arch.	
D5761	reline mandibular partial denture (laboratory)	19 and older		No	No	One of (D5721, D5741, D5761) per 24 Month(s) Per patient per arch.	
D5765	soft liner for complete or partial removable denture – indirect	19 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D5765) per 24 Month(s) Per patient per arch.	
D5810	interim complete denture-maxillary	19 and older		No	No	One of (D5810) per 1 Lifetime Per patient.	
D5811	interim complete denture-mandibular	19 and older		No	No	One of (D5811) per 1 Lifetime Per patient.	
D5820	interim partial denture (maxillary)	19 and older		No	No	One of (D5820) per 1 Lifetime Per patient.	
D5821	interim partial denture-mandibular	19 and older		No	No	One of (D5821) per 1 Lifetime Per patient.	
D5899	unspecified removable prosthodontic procedure, by report	19 and older		Yes	No	Use D5899 for incomplete denture.-Date of service is the date of the initial impression.-Provide reason the tx was not completed.-Submit an itemized statement of the invoice with lab costs.	Lab bills

Exhibit A Benefits Covered for
Healthy Michigan Plan and Medicaid Adult 21+

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

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

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	19 and older		No	No	One of (D6930) per 12 Month(s) Per patient.	

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Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	19 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D7111) per 1 Lifetime Per patient per tooth.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	19 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	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	19 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	No	One of (D7210) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	19 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	No	One of (D7220) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	19 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	No	One of (D7230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	19 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	No	One of (D7240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7250	surgical removal of residual tooth roots (cutting procedure)	19 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	No	One of (D7250) per 1 Lifetime Per patient per tooth. Not allowed by same provider or location that performed extraction.	pre-operative x-ray(s)
D7260	oroantral fistula closure	19 and older		No	No	One of (D7260) per 1 Lifetime Per patient per quadrant.	
D7261	primary closure of a sinus perforation	19 and older	Per Quadrant (UL, UR)	No	No	One of (D7261) per 1 Lifetime Per patient per quadrant.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	19 and older	Teeth 1 - 32	No	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. for Quadrants	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. for Quadrants	pre-operative x-ray(s)
D7471	removal of exostosis - per site	19 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7471) per 1 Lifetime Per patient per arch. for Arches	narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	19 and older		Yes	No	One of (D7472) per 1 Lifetime Per patient.	Photograph
D7473	removal of torus mandibularis	19 and older	Per Quadrant (LL, LR)	Yes	No	One of (D7473) per 1 Lifetime Per patient per quadrant.	Photograph
D7485	surgical reduction of osseous tuberosity	19 and older	Per Quadrant (UL, UR)	Yes	No	One of (D7485) per 1 Lifetime Per patient per quadrant.	Photograph
D7510	incision and drainage of abscess - intraoral soft tissue	19 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	No		narr. of med. necessity, pre-op x-ray(s)
D7970	excision of hyperplastic tissue - per arch	19 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient per arch.	narrative of medical necessity
D7971	excision of pericoronal gingiva	19 and older	Teeth 1 - 32	No	No	One of (D7971) per 24 Month(s) Per patient per tooth.	

Exhibit A Benefits Covered for
Healthy Michigan Plan and Medicaid Adult 21+

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7972	surgical reduction of fibrous tuberosity	19 and older		Yes	No	One of (D7972) per 1 Lifetime Per patient per arch.	narrative of medical necessity

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General Anesthesia and IV Sedation will be received on a case by case basis for medical necessity.
The administration of nitrous oxide, with or without local anesthetic, but without other agents, is not reimbursable.

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

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Pre-Payment Review Required**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9222	deep sedation/general anesthesia first 15 minutes	19 and older		No	No	One of (D9222, D9239) per 1 Day(s) Per patient. Not allow on same date as D9239, D9243, and D9248.	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	19 and older		No	No	Three of (D9223) per 1 Day(s) Per patient. Must be billed with D9222. Not allow on same date as D9239, D9243, and D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	19 and older		No	No	One of (D9222, D9239) per 1 Day(s) Per patient. Not allow on same date as D9222 and D9223, and D9248.	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	19 and older		No	No	Three of (D9243) per 1 Day(s) Per patient. Must be billed with D9239. Not allow on same date as D9222 and D9223, and D9248.	
D9248	non-intravenous moderate sedation	19 and older		No	No	One of (D9248) per 1 Day(s) Per patient. Not allowed on same day as D9222, D9223, D9239, and D9243.	
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19 and older		No	No	One of (D0120, D0140, D0150, D9310) per 6 Month(s) Per patient. Not allowed if D0120, D0140, D0150 has been completed with same provider within 6 months.	
D9420	hospital or ambulatory surgical center call	19 and older		No	No	One of (D9420) per 1 Day(s) Per patient.	
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	19 and older		No	No		