DentaQuest, LLC

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

Dental Care Plus Group

DentaTrust PPO Pediatric High
DentaTrust PPO Pediatric Low
DentaTrust PPO Family High
DentaTrust PPO Family Low
DentaSpan PPO Pediatric High
DentaSpan PPO Pediatric Low
DentaSpan PPO Family High
DentaSpan PPO Family Low

Office Reference Manual

PO Box 2906
Milwaukee, WI 53201-2906
888-307-6547
www.dentaquest.com

DentaQuest, LLC
Address and Telephone Numbers

Provider Services
PO Box 2906
Milwaukee, WI 53201-2906
888-307-6547
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
800-439-7807

TDD (Hearing Impaired)
711 or 800-466-7566

Special Needs Member Services (DentaQuest)
800.660.3397

Fraud Hotline
800.237.9139

Credentialing
PO Box 2906
Milwaukee, WI 53201-2906

Credentialing Hotline: 888.458.2137

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

Authorizations should be sent to:
DENTAQUEST of MO - Authorizations
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

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 privacy and to be treated with respect and recognition of their dignity when receiving dental care.

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

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

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

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

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

Likewise:

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

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.

* * *

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
Table of Contents

Section **Page**

1.00 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

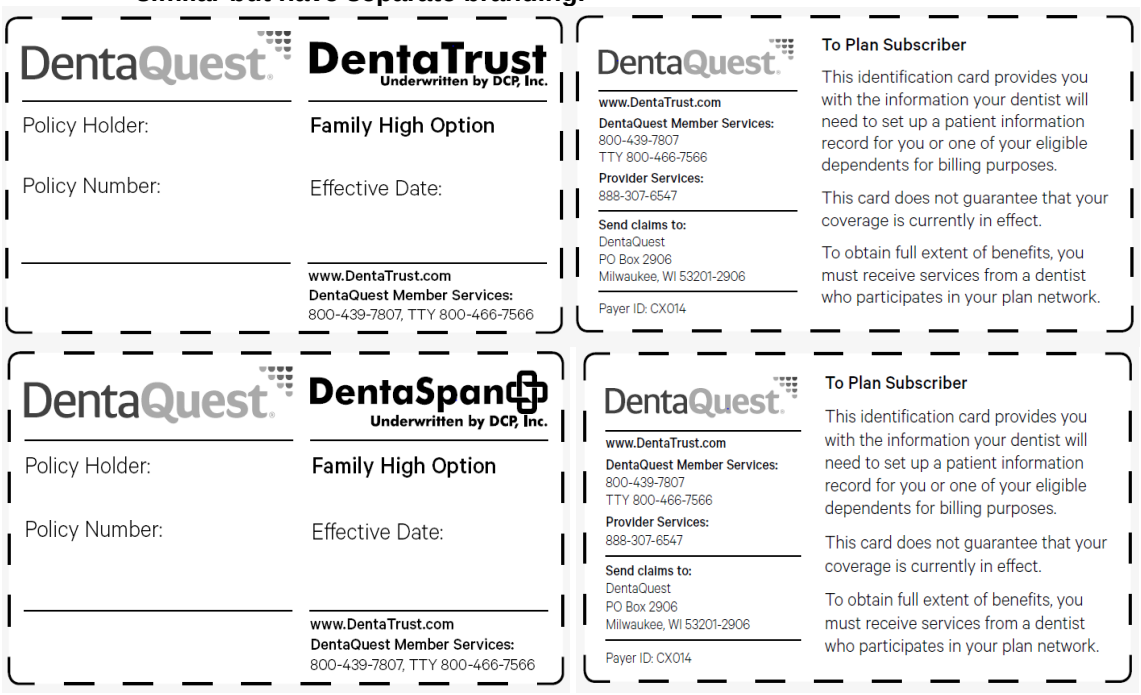
Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

1.02 Member Identification Card

Health Plan Members receive identification cards from the Plans. 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 Health Plan ID Card. DentaTrust and DentaSpan cards are similar but have separate branding.



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.**

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.dentaquestgov.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Provider 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 Provider 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.dentaquestgov.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 Provider Service Department at 888-307-6547. 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.

1.04 Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Provider Service department at 888-307-6547 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 Provider 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 on below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the member information you entered, you will be transferred to a Provider Service Representative.

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

1. Call DentaQuest Provider Service at 888-307-6547.
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 Provider Service Department at 888-307-6547. They will be able to assist you in utilizing either system.

2.00 Authorization of Treatment

2.01 Member Cost Sharing Responsibilities

When members use their DentaTrust or DentaSpan benefits, they may be responsible for making payments toward those services. The amount they may need to pay varies based on the service received and the product they are enrolled under. Dental services provided by an out-of-network provider are covered. See the *Benefits Chart* below for details on cost-sharing for each Exchange product and the *Definitions* section for terms you may not be familiar with.

Depending on the service, members may be expected to pay one or more of the following:

- Copayment
- Coinsurance
- Deductible

Once members have reached their out-of-pocket maximum for cost-sharing with in-network providers, DentaTrust and DentaSpan will cover 100% of the allowed amount for covered services. Members will also be 100% responsible for services that are not covered as part of their Evidence of Coverage.

All details regarding member responsibilities for the following policies are included:

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1. DentaTrust PPO Pediatric High Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
Class I - **Diagnostic and Preventive Services**	Per covered individual: None	100%	Per covered individual: None	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per *Policy:* $150	80%	Per covered individual: $50 Per *Policy:* $150	80%
Class III - **Complex Dental Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy:* $150	50%
Class IV - **Orthodontics Medically Necessary**	Per covered individual None	50%	Per covered individual: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges.

DEDUCTIBLES

Restorative and other Basic Services, and Complex Dental Services described above are subject to a deductible for each *covered individual* in each contract.

OUT OF POCKET MAXIMUM

The out of pocket maximum expense related to in-network *covered services* is limited to $350 for a one child *Policy* and $700 for a multiple child *Policy*.

WAITING PERIOD

Diagnostic and Preventive Services, Restorative and other Basic Services, Complex Dental Services, and Orthodontic serves are not subject to a waiting period.

2. DentaTrust PPO Pediatric Low Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
Class I - **Diagnostic and Preventive Services**	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy:* $150	50%
Class III - **Complex Dental Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy:* $150	50%
Class IV - **Orthodontics Medically Necessary**	Per covered individual None	50%	Per covered individual: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges.

DEDUCTIBLES

Restorative and other Basic Services, and Complex Dental Services described above are subject to a deductible for each *covered individual* in each *Policy*.

OUT OF POCKET MAXIMUM

The out of pocket maximum expense related to in-network *covered services* is limited to $350 for a one child *Policy* and $700 for a multiple child *Policy*.

WAITING PERIOD

Diagnostic and Preventive Services, Restorative and other Basic Services, Complex Dental Services, and Orthodontic serves are not subject to a waiting period.

3. DentaTrust PPO Family High Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
Class I - **Diagnostic & Preventive Services**	Per covered individual: None	100%	Per covered individual: None	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per family maximum: $150	80%	Per covered individual: $50 Per family maximum: $150	80%
Class III - **Complex Dental Services**	Per covered individual: $50 Per family maximum: $150	50%	Per covered individual: $50 Per family maximum: $150	50%
Class IV - **Orthodontics** Medically Necessary	Per covered individual None	50%	Per covered individual: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges.

DEDUCTIBLES
Restorative and other Basic Services, and Complex Dental Services described above are subject to a $50 deductible for each *covered individual* in each *Policy*. The total deductible payment for all *covered individuals* shall not exceed $150 for Restorative and other Basic Services, and Complex Dental Services. This means the *covered individual(s)* must pay the first $50 of benefits provided in each *Policy*, not to exceed $150 for families with three or more *covered individuals*.

OUT OF POCKET MAXIMUM
For *covered individuals* under age 19, the out of pocket maximum related to in-network *covered services* is limited to $350 per *Policy* with one *covered individual* under age 19 and $700 per *Policy* with two or more *covered individuals* under age 19. The out of pocket maximum does not apply to services received from *non-contracting dentists*.
For *covered individuals* age 19 and over, there is no out of pocket maximum.

ANNUAL LIMITS and MAXIMUMS
For *covered individuals* under age 19, there are no annual limits or maximums on our payment for in-network *covered services*. For *covered individuals* age 19 and over, total benefits payable in the *benefit period* are limited to a maximum of $1,000 for each *covered individual.*

WAITING PERIOD
For *covered individuals* under age 19, Diagnostic and Preventive Services, Restorative and other Basic Services, Complex Dental Services, and Orthodontic serves are not subject to a waiting period. For *covered individuals* age 19 and over, Restorative and other Basic Services are subject to a six (6) month waiting period. Complex Dental Services are subject to a twelve (12) month waiting period.

DEPENDENT COVERAGE
Dependent children are covered up to age 26.

4. DentaTrust PPO Family Low Coverage Schedule

SCHEDULE

Coverage Type	Deductible In-Network	In-Network Plan Pays	Deductible Out-of-Network	Out-of-Network Plan Pays
Class I - **Diagnostic & Preventive Services**	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per family maximum: $150	50%	Per covered individual: $50 Per family maximum: $150	50%
Class III - **Complex Dental Services**	Per covered individual: $50 Per family maximum: $150	50%	Per covered individual: $50 Per family maximum: $150	50%
Class IV - **Orthodontics** Medically Necessary	Per covered individual None	50%	Per covered individual: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges.

DEDUCTIBLES
Restorative and other Basic Services, and Complex Dental Services described above are subject to a $50 deductible for each *covered individual* in each *Policy*. The total deductible payment for all *covered individuals* shall not exceed $150 for Restorative and other Basic Services, and Complex Dental Services. This means the *covered individual(s)* must pay the first $50 of benefits provided in each *Policy*, not to exceed $150 for families with three or more *covered individuals.*

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DEPENDENT COVERAGE
Dependent children are covered up to age 26.

5. DentaSpan PPO Pediatric High Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
Class I - **Diagnostic and Preventive Services**	Per covered individual: None	100%	Per covered individual: None	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per *Policy:* $150	80%	Per covered individual: $50 Per *Policy:* $150	80%
Class III - **Complex Dental Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy:* $150	50%
Class IV - **Orthodontics Medically Necessary**	Per covered individual None	50%	Per covered individual: None	50%

NOTE: *Non-contracting dentists* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges.

DEDUCTIBLES

Restorative and other Basic Services, and Complex Dental Services described above are subject to a deductible for each *covered individual* in each contract.

OUT OF POCKET MAXIMUM

The out of pocket maximum expense related to in-network *covered services* is limited to $350 for a one child *Policy* and $700 for a multiple child *Policy*.

WAITING PERIOD

Diagnostic and Preventive Services, Restorative and other Basic Services, Complex Dental Services, and Orthodontic serves are not subject to a waiting period.

6. DentaSpan PPO Pediatric Low Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
Class I - **Diagnostic and Preventive Services**	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%	Per covered individual: $10.00 co-payment on routine exams and prophylaxis per visit	100%
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WAITING PERIOD

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7. DentaSpan PPO Family High Coverage Schedule

SCHEDULE

Coverage Type	**Deductible In-Network**	**In-Network Plan Pays**	**Deductible Out-of-Network**	**Out-of-Network Plan Pays**
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DEPENDENT COVERAGE
Dependent children are covered up to age 26.

8. DentaSpan PPO Family Low Coverage Schedule

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DEPENDENT COVERAGE
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Code	Description

Class I - Diagnostic and Preventative Services

Diagnostic and Treatment Services	
D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation
D0180	Comprehensive periodontal evaluation
D0210	Intraoral – complete set of radiographic images including bitewings
D0220	Intraoral - periapical radiographic image
D0230	Intraoral - additional periapical image
D0240	Intraoral - occlusal radiographic image
D0270	Bitewing - single image
D0272	Bitewings - two images
D0274	Bitewings - four images
D0277	Vertical bitewings – 7 to 8 images
D0330	Panoramic radiographic image
D0340	Cephalometric radiographic image
D0350	Oral / Facial Photographic Images
D0391	Interpretation of Diagnostic Image
D0470	Diagnostic Models

Preventative Services	
D1110	Prophylaxis - Adult
D1120	Prophylaxis – Child
D1206	Topical Fluoride - Varnish
D1208	Topical application of fluoride (excluding prophylaxis)
D1351	Sealant - per tooth - unrestored permanent molars
D1352	Preventative resin restorations in a moderate to high caries risk patient - permanent tooth
D1510	Space maintainer – fixed – unilateral
D1516	Space maintainer – fixed – bilateral, maxillary
D1517	Space maintainer – fixed – bilateral, mandibular
D1520	Space maintainer - removable – unilateral
D1526	Space maintainer – removable – bilateral, maxillary
D1527	Space maintainer – removable – bilateral, mandibular
D1551	Re-cement or re-bond bilateral space maintainer - maxillary
D1552	Re-cement or re-bond bilateral space maintainer - mandibular
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant

Additional Procedures covered as Basic Services	
D9110	Palliative treatment of dental pain – minor procedure

Code	Description

Class II

	Minor Restorative Services
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	Amalgam - three surfaces, primary or permanent
D2161	Amalgam - four or more surfaces, primary or permanent
D2330	Resin–based composite - one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2391	Resin–based composite - one surface, posterior
D2392	Resin-based composite - two surfaces, posterior
D2393	Resin-based composite - three surfaces, posterior
D2394	Resin-based composite - four or more surfaces (posterior)
D2910	Re-cement inlay
D2920	Re-cement crown
D2929	Prefabricated porcelain crown - primary
D2930	Prefabricated stainless steel crown - primary tooth
D2931	Prefabricated stainless steel crown - permanent tooth
D2940	Protective Restoration
D2951	Pin retention - per tooth, in addition to restoration
	Endodontic Services
D3220	Therapeutic pulpotomy (excluding final restoration)
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)and for primary molars and cuspids
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment.
	Periodontal Services
D4341	Periodontal scaling and root planning-four or more teeth per quadrant
D4342	Periodontal scaling and root planning-one to three teeth, per quadrant
D4910	Periodontal maintenance
D7921	Collect - Apply Autologous Products
	Prosthodontic Services
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture - mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth - complete denture (each tooth)

D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	Repair cast partial framework, maxillary
D5630	Repair or replace broken clasp
D5640	Replace broken teeth - per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5710	Rebase complete maxillary denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5730	Reline complete maxillary denture
D5731	Reline complete mandibular denture
D5740	Reline maxillary partial denture
D5741	Reline mandibular partial denture
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory) Rebase/Reline
D5850	Tissue conditioning (maxillary)
D5851	Tissue conditioning (mandibular)
D6930	Recement fixed partial denture
D6980	Fixed partial denture repair, by report

Oral Surgery

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy - intentional partial tooth removal
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7310	Alveoloplasty in conjunction with extractions - per quadrant
D7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471	Removal of exostosis
D7510	Incision and drainage of abscess - intraoral soft tissue
D7910	Suture of recent small wounds up to 5 cm

D7971	Excision of pericoronal gingiva

Code	Description

Class III - Complex Dental Services

Major Restorative Services	
D0160	Detailed and extensive oral evaluation - problem focused, by report
D2510	Inlay - metallic – one surface – An alternate benefit will be provided
D2520	Inlay - metallic – two surfaces – An alternate benefit will be provided
D2530	Inlay - metallic – three surfaces – An alternate benefit will be provided
D2542	Onlay - metallic - two surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces
D2740	Crown - porcelain/ceramic substrate
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominately base metal
D2752	Crown - porcelain fused to noble metal
D2753	Crown - porcelain fused to titanium and titanium alloys
D2780	Crown - 3/4 cast high noble metal
D2781	Crown - 3/4 cast predominately base metal
D2783	Crown - 3/4 porcelain/ceramic
D2790	Crown - full cast high noble metal
D2791	Crown - full cast predominately base metal
D2792	Crown - full cast noble metal
D2794	Crown – titanium
D2950	Core buildup, including any pins
D2954	Prefabricated post and core, in addition to crown
D2980	Crown repair, by report
D2981	Inlay Repair
D2982	Onlay Repair
D2983	Veneer Repair
D2990	Resin infiltration/smooth surface

Endodontic Services	
D3310	Anterior root canal (excluding final restoration)
D3320	Bicuspid root canal (excluding final restoration)
D3330	Molar root canal (excluding final restoration)
D3346	Retreatment of previous root canal therapy-anterior
D3347	Retreatment of previous root canal therapy-bicuspid
D3348	Retreatment of previous root canal therapy-molar
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resprption, etc)

D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410	Apicoectomy/periradicular surgery - anterior
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3450	Root amputation - per root
D3920	Hemisection (including any root removal) - not including root canal therapy
	Periodontal Services
D4210	Gingivectomy or gingivoplasty – four or more teeth
D4211	Gingivectomy or gingivoplasty – one to three teeth
D4212	Gingivectomy or gingivoplasty - with restorative procedures, per tooth
D4240	Gingival flap procedure, four or more teeth
D4249	Clinical crown lengthening-hard tissue
D4260	Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
D4270	Pedicle soft tissue graft procedure
D4273	Subepithelial connective tissue graft procedures (including donor site surgery)
D4277	Free soft tissue graft9 1st tooth
D4278	Free soft tissue graft-additional teeth
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
	Prosthodontic Services
D5110	Complete denture – maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture – maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant
D6010	Endosteal Implant
D6012	Surgical Placement of Interim Implant Body
D6040	Eposteal Implant
D6050	Transosteal Implant, Including Hardware

D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar – implant or abutment supported
D6056 Prefabricated Abutment
D6058 Abutment supported porcelain ceramic crown
D6059 Abutment supported porcelain fused to high noble metal
D6060 Abutment supported porcelain fused to predominately base metal crown
D6061 Abutment supported porcelain fused to noble metal crown
D6062 Abutment supported cast high noble metal crown
D6063 Abutment supported cast predominately base metal crown
D6064 Abutment supported cast noble metal crown
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported porcelain fused to high metal crown
D6067 Implant supported metal crown
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture
D6072 Abutment supported retainer for cast high noble metal fixed partial denture
D6073 Abutment supported retainer for predominately base metal fixed partial denture
D6074 Abutment supported retainer for cast noble metal fixed partial denture
D6075 Implant supported retainer for ceramic fixed partial denture
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture
D6077 Implant supported retainer for cast metal fixed partial denture
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch
D6080 Implant Maintenance Procedures
D6082 Implant supported crown - porcelain fused to predominantly base alloys
D6083 Implant supported crown - porcelain fused to noble alloys
D6084 Implant supported crown - porcelain fused to titanium and titanium alloys
D6086 Implant supported crown - predominantly base alloys
D6087 Implant supported crown - noble alloys
D6088 Implant supported crown - titanium and titanium alloys
D6090 Repair Implant Prosthesis
D6091 Replacement of Semi-Precision or Precision Attachment
D6095 Repair Implant Abutment
D6097 Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098 Implant supported retainer - porcelain fused to predominantly base alloys
D6099 Implant supported retainer for FPD - porcelain fused to noble alloys
D6100 Implant Removal
D6101 Debridement per implant defect, covered if implants are covered
D6102 Debridement and osseous per implant defect, covered if implants are covered
D6103 Bone graft per implant defect, covered if implants are covered
D6104 Bone graft implant replacement, covered if implants are covered
D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys

D6121 Implant supported retainer for metal FPD – predominantly base alloys
D6122 Implant supported retainer for metal FPD – noble alloys
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys
D6190 Implant Index
D6195 Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominately base metal
D6212 Pontic - cast noble metal
D6214 Pontic – titanium
D6240 Pontic - porcelain fused to high noble metal
D6241 Pontic porcelain fused to predominately base metal
D6242 Pontic - porcelain fused to noble metal
D6243 Pontic - porcelain fused to titanium and titanium alloys
D6245 Pontic - porcelain/ceramic
D6545 Retainer -cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominately base metal
D6752 Crown - porcelain fused to noble metal
D6753 Retainer crown - porcelain fused to titanium and titanium alloys
D6780 Crown - 3/4 cast high noble metal
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6784 Retainer crown ¾ - titanium and titanium alloys
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D9944 Occlusal guard – hard appliance, full arch
D9945 Occlusal guard – soft appliance, full arch
D9946 Occlusal guard – hard appliance, partial arch

Class IV Orthodontics Medical Necessity

Code	Description
	Orthodontic Services - limited to members under the age of 21
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment visit
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)
	Anesthesia Services
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each 15 minutes
	Intravenous Sedation
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minutes
	Consultations
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
	Medications
D9610	Therapeutic drug injection, by report
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites
	Post Surgical Services
D9930	Treatment of complications (post-surgical) unusual circumstances, by report

2.02 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 section 12). 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" must include:

1) Radiographs, narrative, or other information where requested (See Exhibits A - E 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 A - E) 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 a 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. 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.

2.03 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.fast.nea.com or call NEA at:

800.782.5150

2.04 EMERGENCY Treatments and Authorizations

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

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

3.00 Participating Hospitals

Dental Care Plus does not pay for hospitalization services performed outside of dental offices. In the scenario of a dental service being performed in a hospital unit, please direct your patient to their Medical Insurer for coverage/payment of medical services. Following the normal procedures and ORM requirements, Dental Care Plus will pay for the dental services conducted in this scenario, but will not pay for the medical services. If you have any questions regarding the role of Dental Care Plus in hospitalization or utilization of a medical center for dental services, please call 513-554-1100.

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.dentaquestgov.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.dentaquestgov.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 to how to perform Provider Self Registration: you may also contact DentaQuest's Provider Service Department at 888-307-6547. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim

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

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

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.dentaquestgov.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 Provider Service Department at 888-307-6547. 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@greatdentalplans.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 Provider Service Department with any questions you may have regarding claim submission or your remittance.

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

4.11 Direct Deposit

As a benefit to participating Providers, DentaQuest offers 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 Direct Deposit, Providers must:

- Complete and sign the Direct Deposit Form found on the website.
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Form and voided check to DentaQuest.
    - Via Fax – 262.241.4077
    - Via Mail – DentaQuest, LLC.
      PO Box 2906
      Milwaukee, WI 53201-2906

      ATTN: PDA Department

The Direct Deposit Form must be legible to prevent delays in processing. Providers should allow up to six weeks for Direct Deposit 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 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 Direct Deposit are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.dentaquestgov.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 HIIPAA. 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 (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

  Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Service department at 888-307-6547 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.dentaquestgov.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 Complaints and Appeals (Policies 200.010, 200.011, 200.013, 200.020A and 500.024E)

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

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

B. Complaint: A complaint means an oral allegation of improper or in appropriate action, or an oral statement of dissatisfaction with covered services, post-service claims payment or policies that do not fall within the definition of a grievance.

C. Grievance: A grievance means a written complaint submitted by or on behalf of an enrollee regarding: (1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or matters pertaining to the contractual relationship between an enrollee and the Company; or (3) matters pertaining to the contractual relationship between an enrollee and the Company.

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

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

Note: Copies of DentaQuest policies and procedures can be requested by contacting Provider Service at 888-307-6547. (Policies 200.010, 200.011, 200.013, 200.017)

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7.00 Utilization Management Program (Policies 500 Series)

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 and Abuse (Policies 700 Series)

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

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

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

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

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

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; and
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Service Department at 888-307-6547 or via e-mail at:

denelig.benefits@dentaquest.com.

9.00 The Patient Record

A. Organization

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

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

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

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

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

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

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

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

1. Adequate documentation of registration information which requires entry of these items:

   a. Patient's first and last name.
   b. Date of birth.
   c. Sex.
   d. Address.
   e. Telephone number.
   f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:

    a. Current medical treatment.
    b. Significant past illnesses.
    c. Current medications.
    d. Drug allergies.
    e. Hematologic disorders.
    f. Cardiovascular disorders.
    g. Respiratory disorders.
    h. Endocrine disorders.
    i. Communicable diseases.
    j. Neurologic disorders.
    k. Signature and date by patient.
    l. Signature and date by reviewing dentist.
    m. History of alcohol and/or tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

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

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

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

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

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

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

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

7. Radiographs which are:

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

8. An indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

10. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:

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

10.00 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.
- Emergency care must be available within 24 hours.
- Urgent care must be available within 48 hours.

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

11.00 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.

12.00 Health Guidelines – Ages 0-18 Years

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

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

PERIODICITY RECOMMENDATIONS					
Age	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Clinical oral examination (1)	X	X	X	X	X
Assess oral growth and development (2)	X	X	X	X	
Caries-risk assessment (3)	X	X	X	X	X
Radiographic assessment (4)	X	X	X	X	X
Prophylaxis and topical fluoride treatment (3,4)	X	X	X	X	X
Fluoride supplementation (5)	X	X	X	X	X
Anticipatory guidance/counselling (6)	X	X	X	X	X
Oral Hygiene Counseling (7)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient/ parents/ caregivers	Patient
Dietary Counseling (8)	X	X	X	X	X
Injury, Prevention Counseling (9)	X	X	X	X	X
Counseling for non-nutritive habits (10)	X	X	X	X	X
Counseling for speech/language development	X	X	X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Assessment for pit and fissure sealants			X	X	X
Substance abuse counseling				X	X
Counseling for intraoral/perioral piercing				X	X
Assessment and/or removal of third molars					X
Transition to adult dental care					X

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent, as child matures, jointly with parent, then, when indicated, only child.
8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

13.00 Clinical Criteria

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

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

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria 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.

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

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

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

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

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

available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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

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

13.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

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

Criteria

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

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

13.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

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

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

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

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

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

Authorizations for Crowns will not meet criteria if:

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

13.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

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

Root canal therapy must meet the following criteria:

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

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

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial denture.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

13.04 Criteria for Stainless Steel Crowns

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

Documentation needed for authorization of procedure:

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

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

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

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

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

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

- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

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

- Request should include a dated post-endodontic radiograph.

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

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

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

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

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

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

13.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Criteria

General

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction. Please review the benefit limitations in the Exhibits in the back of this Office Reference Manual in the D5000's series of codes.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- The replacement teeth should be anatomically full sized teeth.
- Lost, stolen or damaged and un-repairable appliance will be replaced only if replacement is needed due to circumstances beyond the recipient's control.

Authorizations for Removable prosthesis will not meet criteria:

- If the member has already received a prosthesis within the benefit limitation period noted in the Exhibits in the back of this Office Reference Manual.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, please review the benefit limitations in the Exhibits in the back of this ORM to determine if the member is eligible for a replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed.
- Relines will be reimbursed per the benefit limitations in the Exhibits in the back of this ORM.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

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

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

13.06 Criteria for the Excision of Bone Tissue

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

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

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.

13.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.

- The tooth has less than 50% bone support.

- The tooth has subosseous and/or furcation caries.

- The tooth is a primary tooth with exfoliation imminent.

- The tooth apex is surrounded by severe pathologic destruction of the bone.

- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

13.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

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

Criteria

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

13.09 Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

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

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or

microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

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

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

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

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

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

13.10 Criteria for Orthodontic Treatment

Comprehensive orthodontic treatment is considered medically necessary when adequate corrective treatment is not achievable with less extensive means, and one of the following criteria is met:

- Dentition affected by significant cleft palate, craniofacial or other congenital or developmental disorder
- Significant skeletal disharmony requiring combination of orthodontic treatment and orthognathic surgery for correction
- Overjet greater than 9mm or reverse overjet greater than 3.5mm
- Anterior openbite greater than 4mm

Or one of the following criteria is met and demonstrated functional impairment is present:

- Impeded eruption of teeth (with the exception of third molars) due to crowding, displacement, the presence of supernumerary teeth, retained deciduous teeth or other pathological cause, where conservative removal of the ectopic tooth would create a significant functional deficit in biting or chewing
- Severe crowding of greater than 7mm in either the maxillary or mandibular arch

- Extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for prosthetic treatment
- Significant posterior openbite (not involving partially erupted teeth or teeth slightly out of occlusion;
- Anterior crossbite involving permanent incisors or canines creating a functional interference and a resulting functional shift, or gingival stripping
- Posterior transverse discrepancies causing buccal or lingual crossbite involving permanent molar teeth and creating a functional interference and a resulting functional shift;
- Deep anterior overbite of multiple incisors resulting in soft tissue impingement or trauma
  Overjet greater than 6mm or reverse overjet greater than 1mm
- Other conditions as deemed medically necessary
- **To qualify the standard scoring tool for MO is the HLD form with a qualifying score of 28 for an approval.**

APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

"DHS" means the Department of Human Services, as described in A.R.S. Section 36-2901, *et seq*., which is composed of the Administration, contractors, subcontractors and other Providers entering into arrangements through which health care services are provided to eligible persons.

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

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

"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.

"DentaQuest" shall refer to DentaQuest of Missouri, LLC

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

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

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

"Out-of-Pocket Maximum" is the limit on how much you have to pay out-of-pocket each year for in-network copayments, coinsurance, and deductibles paid for covered services received during a calendar year. After you have reached the annual maximum individual or family out-of-pocket limit for this plan, the plan pays 100% of the cost for in-network covered services for the remainder of the year. The amounts you pay for copayments and coinsurance for in-network covered

services count toward your maximum out-of-pocket amount. Amounts you pay for plan premiums, balance-billed charges from non-network services, and health care services this plan does not cover are not included in the maximum out-of-pocket limit. Any amount you pay for non-covered charges is not applicable toward your maximum out-of-pocket amount.

"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.

"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.

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

"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.

"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.dentaquestgov.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:

- Missouri Orthodontic Criteria For Medical Necessity
- Evaluation Criteria for Comprehensive Orthodontic Treatment
- Orthodontic Services
- Orthodontic Continuation of Care Form
- OrthoCAD Submission Form
- Handicapping Labio-lingual Deviation Index (HLD) Score Sheet
- 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 Provider Service @ 888-307-6547.

You can also find the forms within this manual.

First Review ___
Second Review ___

Models ___
Orthocad ___

Ceph Films ___
X-Rays ___
Photos ___
Narrative ___

DentaQuest, LLC

MISSOURI ORTHODONTIC CRITERIA FOR MEDICAL NECESSITY

Patient Name: _____ **DOB:** _____

HealthPlan: _____ **Doctor Name:** _____

CRITERIA	YES	NO
Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
Demonstrates a large anterior –posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III).		
Anterior crossbite. (Involves more than two teeth in crossbite).		
Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, not a single tooth in crossbite).		
Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
Impacted canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where canines are going to erupt ectopically).		

WHEN ALL ARE ANSWERED "NO", PLEASE REFER TO APPENDIX "A" □

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS
Richard Nellen, DDS Paul Schulze, DDS

DentaQuest

EVALUATION CRITERIA FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Check the symptoms and signs of physical conditions that you observe in this patient.

Dentofacial Abnormality

_____ Marked protruding upper jaw and teeth
_____ Underdeveloped lower jaw and teeth, receding chin
_____ Excessively spaced front teeth
_____ Upper and lower teeth protruding so much that lips cannot be brought together without strain
_____ Marked protruding lower jaw and teeth
_____ Extremely “crooked” front teeth
_____ Marked asymmetry of lower face or transverse deficiencies
_____ Clefts of lip or face
_____ Abnormalities of dental development
_____ Other (explain in comments section at bottom of page)

Tissue Damage Related to Malocclusion

_____ Marked recession of gums
_____ Loosened permanent teeth
_____ Other (explain in comments section at bottom of page)

Mastication Related to Malocclusion

_____ Extreme grimacing or excessive motions of the oral-facial muscles during swallowing
_____ Socially unacceptable behavior during eating because of necessary compensation for anatomic facial deviations
_____ Pain in jaw when eating
_____ Other (explain in comments section at bottom of page)

Respiration and Speech Related to Malocclusion

_____ Postural abnormalities with breathing difficulties
_____ Malocclusion of jaws related to chronic mouth breathing
_____ Lisping or other speech articulation errors in children 9 years old or older
_____ History of or recommendation for speech therapy
_____ Other (explain in comments section at bottom of page)

Comments: _____
_____
_____
_____
_____
_____
_____

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS

Richard Nellen, DDS Paul Schulze, DDS

ORTHODONTIC SERVICES

Comprehensive Orthodontics

Coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions. Coverage is further limited to children under age 21. Only one course of orthodontic treatment per recipient, per lifetime is covered.

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

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

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

OrthoCAD Submission Form

Date:_____

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

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

Treatment Requested

Code:	**Description of request:**

MO Orthodontic Continuation of Care Submission Form

Date: _____

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN of ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Months of Active Treatment Completed:	Months of Active Treatment Remaining:

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE BETWEEN MEDICAID PLANS

☐ Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different **Medicaid** program/vendor.

Required for submission:

- ☐ Completed ADA form for preauthorization of CDT Code **D8999**.
- ☐ Copy of original Medicaid Prior Authorization for Comprehensive Orthodontic Treatment (Prior Authorization from Medicaid program/vendor for Comprehensive Orthodontic Treatment approved prior to initiation of orthodontic treatment).

****If required information above is cannot be provided, the case will be reviewed as outlined below.***

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE FROM NON-MEDICAID TO MEDICAID

☐ Member initiated treatment while covered by a **NON-Medicaid** program/vendor (FFS or Commercial Insurance plan) OR Self-Pay and Member is now covered by a **Medicaid** program/vendor with the same OR different Provider.

Required for submission:

- ☐ Completed ADA form for preauthorization of CDT Code **D8999**.
- ☐ Diagnostic records (a copy of the original study models/OrthoCad equivalent and/or a complete set of diagnostic photographs and/or a panorex film). Progress records will be accepted if original records are not available. Documentation should demonstrate qualifying criteria for severe handicapping malocclusion.

CHANGES THAT DO NOT HAVE TO BE SUBMITTED FOR CONTINUATION OF CARE PREAUTHORIZATION

- *Changes between treating providers that are affiliated with the same group practice and changes between different affiliated practice locations. To ensure timely payment, please make sure that any claim is submitted with the correct Group(Billing) and Provider NPI information.*
- *Initiation of Comprehensive Orthodontic Treatment after completion of Interceptive or Limited Orthodontic Treatment (Phased treatment). Please submit a prior-authorization (with any required documentation per plan) with the correct ADA Code for Comprehensive Ortho (D8070-D8090)*

ADA 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

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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. Student Status ☐ FTS ☐ PTS

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian signature Date

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

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
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 Prior Placement (MM/DD/CCYY)

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

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

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

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

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) –	52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number ( ) –	58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

ADA

American Dental Association
www.ada.org

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

GENERAL INSTRUCTIONS

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

COORDINATION OF BENEFITS (COB)

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

ADDITIONAL PROVIDER IDENTIFIER

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

PROVIDER SPECIALTY CODES

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

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

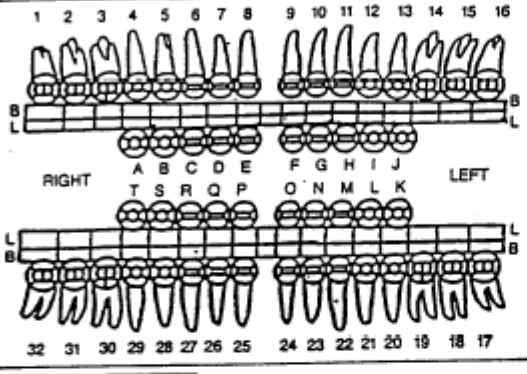
Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

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

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION I II III

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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

RECALL EXAMINATION

PATIENT'S NAME_____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS:_____

_____

_____

RECALL EXAMINATION

PATIENT'S NAME_____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS:_____

_____

_____

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

Authorization for Dental Treatment

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

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

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

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

Provider Change Form

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

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

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

This form may be submitted by

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

Email to: standardupdates@dentaquest.com

Fax to: 262-241-4077

Request for Transfer of Records

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

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

Please have these records sent to:

_____

_____

_____

Signed: _____ Date: _____
(Patient)

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

Address: _____

Address: _____

Phone: _____

APPENDIX B

Covered Benefits (See Exhibits A -E)

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 Provider Service Department directly at:**

888-307-6547, press option 2

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

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

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

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

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

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

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

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

DentaQuest Authorization Process

IMPORTANT

For procedures where "Authorization Required" fields indicate "**yes**".

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

When documentation is requested. i.e. 03330 Preoperative Radiographs of adjacent and opposing teeth.

"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

Exhibit A Benefits Covered for
DentaTrust/DentaSpan - Pediatric 0-18

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

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

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

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

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

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

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	0-18		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient. Not allowed on same day as D0120, D0140, D0150, D0160, D0180 and D9110.	
D0150	comprehensive oral evaluation - new or established patient	0-18		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0210	intraoral - complete series of radiographic images	0-18		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-18		No		
D0230	intraoral - periapical each additional radiographic image	0-18		No		
D0240	intraoral - occlusal radiographic image	0-18		No		

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-18		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient ages 0 to 18.	
D0272	bitewings - two radiographic images	0-18		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient ages 0 to 18.	
D0274	bitewings - four radiographic images	0-18		No	One of (D0270, D0272, D0274) per 6 Month(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	0-18		No	One of (D0277) per 6 Month(s) Per patient.	
D0330	panoramic radiographic image	0-18		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0340	cephalometric radiographic image	0-18		No	Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No		
D0470	diagnostic casts	0-18		No		

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

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

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 18		No	One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	
D1120	prophylaxis - child	0-12		No	One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	
D1206	topical application of fluoride varnish	0-18		No	Two of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 21.	
D1208	topical application of fluoride - excluding varnish	0-18		No	Two of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 21.	
D1351	sealant - per tooth	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1352) per 36 Month(s) Per patient per tooth ages 0 to 18.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1351, D1352) per 36 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed-unilateral	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D1516	space maintainer --fixed--bilateral, maxillary	0-18		No		
D1517	space maintainer --fixed--bilateral, mandibular	0-18		No		
D1520	space maintainer-removable-unilateral	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D1526	space maintainer --removable--bilateral, maxillary	0-18		No		

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1527	space maintainer --removable--bilateral, mandibular	0-18		No		
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-18	Teeth A - C, H - J	No	Not covered within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-18	Teeth K - M, R - T	No	Not covered within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-18	Teeth A - C, H - M, R - T	No	Not covered within 6 months of initial placement.	

Reimbursement includes local anesthesia.

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 are included as part of the restoration.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

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

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

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2510	inlay - metallic -1 surface	0-18	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2520	inlay-metallic-2 surfaces	0-18	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2530	inlay-metallic-3+ surfaces	0-18	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2542	onlay - metallic - two surfaces	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2783	crown - ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2790	crown - full cast high noble metal	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2794	Crown- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	0-18	Teeth 1 - 32	No	Not allowed within 6 months of delivery.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, A - T	No	Not allowed within 6 months of delivery.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-18	Teeth A - T	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-18	Teeth A - T	No	One of (D2930, D2931) per 60 Month(s) Per patient per tooth ages 0 to 14.	
D2931	prefabricated stainless steel crown-permanent tooth	0-18	Teeth 1 - 32	No	One of (D2930, D2931) per 60 Month(s) Per patient per tooth ages 0 to 14.	
D2940	protective restoration	0-18	Teeth 1 - 32	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2950	core buildup, including any pins when required	0-18	Teeth 1 - 32	Yes	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	0-18	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2980	crown repair, by report	0-18	Teeth 1 - 32	No		
D2981	Inlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	No		
D2982	Onlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	No		
D2983	Veneer repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	No		
D2990	Resin infiltration of incipient smooth surface lesions	0-18	Teeth 1 - 32, A - T	No	One of (D2990) per 36 Month(s) Per patient per tooth.	

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

Surgical root canal treatment or apicoectomy may be necessary to complete treatment, temporary fillings, filling, and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-18	Teeth 1 - 32	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C - H, M - R	No	One of (D3230) per 1 Lifetime Per patient per tooth ages 0 to 5.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	One of (D3240) per 1 Lifetime Per patient per tooth ages 0 to 5.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No		
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No		
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No		
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3450	root amputation - per root	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3920	hemisection (including any root removal), not incl root canal therapy	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes		pre-operative x-ray(s)

Reimbursement includes local anesthesia.

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-18	Teeth 1 - 32, 51 - 82	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-18	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-18	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	0-18		No	One of (D4355) per 1 Lifetime Per patient.	
D4910	periodontal maintenance procedures	0-18		Yes	Four of (D4910) per 12 Month(s) Per patient. 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy not to be combined with D1110 or D1120	pre-op x-ray(s), perio charting

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a fixed prosthesis may be considered when there is one missing maxillary anterior tooth or two missing mandibular anterior teeth and the member's overall status would justify consideration.

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

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

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-18		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	0-18		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	0-18		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	0-18		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	0-18		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	0-18		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	0-18		Yes	One of (D5211, D5212, D5213, D5214, D5282, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	0-18		Yes	One of (D5211, D5212, D5213, D5214, D5282, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5410	adjust complete denture - maxillary	0-18		No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-18		No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-18		No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-18		No	Not covered within 6 months of initial placement.	
D5511	repair broken complete denture base, mandibular	0-18		No		
D5512	repair broken complete denture base, maxillary	0-18		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-18		No		
D5612	repair resin partial denture base, maxillary	0-18		No		
D5621	repair cast partial framework, mandibular	0-18		No		
D5622	repair cast partial framework, maxillary	0-18		No		

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5660	add clasp to existing partial denture	0-18	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5710	rebase complete maxillary denture	0-18		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5720	rebase maxillary partial denture	0-18		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5721	rebase mandibular partial denture	0-18		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5730	reline complete maxillary denture (chairside)	0-18		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5731	reline complete mandibular denture (chairside)	0-18		No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5740	reline maxillary partial denture (chairside)	0-18		No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5741	reline mandibular partial denture (chairside)	0-18		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	0-18		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5751	reline complete mandibular denture (laboratory)	0-18		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5760	reline maxillary partial denture (laboratory)	0-18		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5761	reline mandibular partial denture (laboratory)	0-18		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5850	tissue conditioning, maxillary	0-18		No		
D5851	tissue conditioning,mandibular	0-18		No		

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Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-18	Teeth 1 - 32	Yes	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6012	surgical placement of interim implant body-endosteal implant	0-18	Teeth 1 - 32	Yes	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6040	surgical placement:eposteal implnt	0-18	Per Arch (01, 02, LA, UA)	Yes	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6050	surgical placement-transosteal implant	0-18	Teeth 1 - 32	Yes	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6053	implant/abutment supported removable denture for completely edentulous arch	0-18	Per Arch (01, 02, LA, UA)	Yes		pre-operative x-ray(s)
D6054	implant/abutment supported removable denture for partially endentulous arch	0-18	Per Arch (01, 02, LA, UA)	Yes		pre-operative x-ray(s)
D6055	connecting bar - implant supported or abutment supported	0-18	Teeth 1 - 32	Yes	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6056	prefabricated abutment	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6058	abutment supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6062	abutment supported cast metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6063	abutment supported cast metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6064	abutment supported cast metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6065	implant supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6066	Implant Supported Crown- Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6067	Implant Supported Crown- High Noble Alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6068	abutment supported retainer for porcelain/ceramic FPD	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6075	implant supported retainer for ceramic FPD	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6080	implant maintenance procedure	0-18	Teeth 1 - 32	Yes	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6083	Implant supported crown-porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6086	Implant supported crown- predominately base alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6087	Implant supported crown- noble alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6088	Implant supported crown- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6090	repair implant prosthesis	0-18	Teeth 1 - 32	Yes	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6091	replacement of attachment- implant/abutment prosthesis	0-18		Yes	One of (D6091) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6095	repair implant abutment	0-18	Teeth 1 - 32	Yes	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6097	Abutment supported crown- porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6056, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6097) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6098	Implant supported retainer- porcelain fused to predominately base alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6100	implant removal, by report	0-18	Teeth 1 - 32	Yes	One of (D6100) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-18	Teeth 1 - 32, 51 - 82	Yes		pre-operative x-ray(s)
D6104	Bone graft at time of implant placement	0-18	Teeth 1 - 32, 51 - 82	Yes		pre-operative x-ray(s)
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6121	Implant supported retainer for metal FPD- predominately base alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6122	Implant supported retainer for metal FPD- noble alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6190	radiographic/surgical implant index, by report	0-18	Teeth 1 - 32	Yes	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6195	Abutment Supported Retainer-Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6195) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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

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

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6211	pontic-cast base metal	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6212	pontic - cast noble metal	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6214	Pontic - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6240	pontic-porcelain fused-high noble	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6241	pontic-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6242	pontic-porcelain fused-noble metal	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6545	retainer - cast metal fixed	0-18	Teeth 1 - 32	Yes	One of (D6545, D6548) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-18	Teeth 1 - 32	Yes	One of (D6545, D6548) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6740	retainer crown – porcelain/ceramic	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6750	crown-porcelain fused high noble	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6751	crown-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6752	crown-porcelain fused noble metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6780	crown-3/4 cst high noble metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6790	crown-full cast high noble	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6791	crown - full cast base metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	0-18		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82	Yes	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82	Yes	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1 - 32, 51 - 82	Yes	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative x-ray(s)

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	Yes	Includes splinting and/or stabilization.	pre-operative x-ray(s)
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant performed on the same day. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant performed on the same day. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, post-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	0-18		Yes		narrative of medical necessity

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7921	Collection and application of autologous blood concentrate product	0-18		No	One of (D7921) per 36 Month(s) Per patient.	
D7971	excision of pericoronal gingiva	0-18	Teeth 1 - 32	Yes		narr. of med. necessity, post-op x-ray(s)

Exhibit A Benefits Covered for
DentaTrust/DentaSpan - Pediatric 0-18

General Billing Information for Orthodontics:
The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on this date of service.
If a Member becomes ineligible during treatment and before full payment is made, it is the Member's responsibility to pay the balance for any remaining treatment. Whenever the Member becomes ineligible, the Member is responsible for payment during that time period. The Provider should notify the Member of this requirement prior to beginning treatment.

Participants between the ages of 2 and 18 may qualify for orthodontic care under the program. Participants must have a severe, dysfunctional, handicapping malocclusion as determined by a score of 42 points or greater on the modified salzmann index, or objective documentation that the malocclusion is an impairment of, or a hazard to the ability to eat, chew, speak, or breathe. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered.

Documentation
Previously DentaQuest required plaster models, in addition to other required documentation such as x-rays, to review the necessity of the request for orthodontic treatment. DentaQuest now accepts a complete series of intra-oral photos instead of the plaster models. All other required documentation, including panoramic and cephalometric films, score sheets, and narratives; must be submitted with the photos. This change was made to reduce postage costs for provider; increase the speed with which records are returned, and eliminate the possibility of models being damaged in shipment. If your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:
•Facial photographs (right and left profiles in addition to a straight-on facial view)
•Frontal view, in occlusion, straight-on view
•Frontal view, in occlusion, from a low angle
•Right buccal view, in occlusion
•Left buccal view, in occlusion
•Maxillary Occlusal view
•Mandibular Occlusal view

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements. All other currently required documentation, including panoramic and cephalometric x-rays, narratives, and scoring forms will continue to be required for review.

If your office currently submits digital models through OrthoCad these are still accepted and no change needs to be made regarding the submission of models.

In addition to the photographs, plaster models or digital models, authorization for orthodontia services requires a claim form listing the requested services, the Orthodontic Criteria Index Form, and any other documentation that supports medical necessity.

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

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-18		Yes		Photos, Narrative/treatment plan
D8020	limited orthodontic treatment of the transitional dentition	0-18		Yes		Photos, Narrative/treatment plan
D8030	limited orthodontic treatment of the adolescent dentition	0-18		Yes		Photos, Narrative/treatment plan
D8050	interceptive orthodontic treatment of the primary dentition	0-18		Yes		Photos, Narrative/treatment plan
D8060	interceptive orthodontic treatment of the transitional dentition	0-18		Yes		Photos, Narrative/treatment plan
D8070	comprehensive orthodontic treatment of the transitional dentition	0-18		Yes	Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia; extreme mandibular prognathism; severe asymmetry; ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.	Photos, Narrative/treatment plan
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia; extreme mandibular prognathism; severe asymmetry; ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.	Photos, Narrative/treatment plan
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes		Photos, Narrative/treatment plan
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes		Photos, Narrative/treatment plan
D8660	pre-orthodontic treatment examination to monitor growth and development	0-18		Yes	Used to pay for records only on denied cases.	Photos, Narrative/treatment plan
D8670	periodic orthodontic treatment visit	0-18		Yes	Seven of (D8670) per 1 Lifetime Per patient. Maximum of 7 Quarterly visits reimbursed.	Photos, Narrative/treatment plan
D8680	orthodontic retention (removal of appliances)	0-18		Yes	One of (D8680) per 1 Lifetime Per patient.	Photos, Narrative/treatment plan

Exhibit A Benefits Covered for
DentaTrust/DentaSpan - Pediatric 0-18

Reimbursement includes local anesthesia.

General anesthesia and IV sedation will be received on a case by case basis for medical necessity.

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-18		No		
D9222	deep sedation/general anesthesia first 15 minutes	0-18		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	0-18		Yes	Four of (D9223) per 1 Day(s) Per patient. Not to exceed 60 minutes or 4 units. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		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	0-18		Yes	Four of (D9243) per 1 Day(s) Per patient. Not to exceed 60 minutes or 4 units. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-18		No		
D9610	therapeutic drug injection, by report	0-18		Yes	One (D9610) per 1 Day(s) per patient. Description and dosage of drug and narrative of medical necessity.	narrative of medical necessity
D9613	infiltration of sustained release therapeutic drug--single or multiple sites	0-18		Yes	One of (D9613) per 1 Day(s) Per patient. Allowed only with impaction removal of 1,16,17,32.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		Yes		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit A Benefits Covered for DentaTrust/DentaSpan - Pediatric 0-18

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9945	occlusal guard--soft appliance full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit B Benefits Covered for
DentaTrust/DentaSpan - 19 and Over

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

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

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

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

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

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

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	19 and older		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	19 and older		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient. Not allowed on same day as D0120, D0145, D0150. Not allowed with non-emergent routine services. Not allowed on same day as non-emergency definitive treatment.	
D0150	comprehensive oral evaluation - new or established patient	19 and older		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	19 and older		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	19 and older		No	One of (D0120, D0140, D0150, D0160, D0180) per 6 Month(s) Per patient.	
D0210	intraoral - complete series of radiographic images	19 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	19 and older		No		
D0230	intraoral - periapical each additional radiographic image	19 and older		No		

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	19 and older		No		
D0270	bitewing - single radiographic image	19 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient ages 19 and above.	
D0272	bitewings - two radiographic images	19 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient ages 0 to 18.	
D0274	bitewings - four radiographic images	19 and older		No	One of (D0270, D0272, D0274) per 1 Calendar year(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	19 and older		No	One of (D0277) per 1 Calendar year(s) Per patient.	
D0330	panoramic radiographic image	19 and older		No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	19 and older		No		
D0470	diagnostic casts	19 and older		No		

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

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

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	19 and older		No	One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	
D1120	prophylaxis - child	19 and older		No	One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	
D1206	topical application of fluoride varnish	19 and older		No	Two of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 21.	
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	One of (D1351, D1352) per 36 Month(s) Per patient per tooth.	

Exhibit B Benefits Covered for
DentaTrust/DentaSpan - 19 and Over

Reimbursement includes local anesthesia.

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 are included as part of the restoration.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

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

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

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	19 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) 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	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) 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	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) 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	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient 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	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient 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	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	19 and older	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2520	inlay-metallic-2 surfaces	19 and older	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2530	inlay-metallic-3+ surfaces	19 and older	Teeth 1 - 32	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2510, D2520, D2530) per 24 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2542	onlay - metallic - two surfaces	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2751	crown - porcelain fused to predominantly base metal	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2783	crown - ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Yes	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2753, D2780, D2781, 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	Not allowed within 6 months of delivery.	
D2920	re-cement or re-bond crown	19 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of delivery.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	19 and older	Teeth A - T	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2940	protective restoration	19 and older	Teeth 1 - 32	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2950	core buildup, including any pins when required	19 and older	Teeth 1 - 32	Yes	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	19 and older	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	19 and older	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2980	crown repair, by report	19 and older	Teeth 1 - 32	No		
D2981	Inlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	No		
D2982	Onlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	No		
D2983	Veneer repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	No		
D2990	Resin infiltration of incipient smooth surface lesions	19 and older	Teeth 1 - 32, A - T	No	One of (D2990) per 36 Month(s) Per patient per tooth.	

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

Surgical root canal treatment or apicoectomy may be necessary to complete treatment, temporary fillings, filling, and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	19 and older	Teeth 1 - 32, A - T	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	19 and older	Teeth 1 - 32	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	19 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth. Only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth.	
D3346	retreatment of previous root canal therapy-anterior	19 and older	Teeth 6 - 11, 22 - 27	No		
D3347	retreatment of previous root canal therapy - premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No		
D3348	retreatment of previous root canal therapy-molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No		
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3354	Pulpal regeneration includes completed regenerative trt of an immature perm tooth with a necrotic pulp. Includes removal of intracanal medication and procs necessary to regenerate cont'd root development and neccessary xrays.	19 and older	Teeth 1 - 32	No		pre-operative x-ray(s)
D3410	apicoectomy - anterior	19 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3450	root amputation - per root	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3920	hemisection (including any root removal), not incl root canal therapy	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes		pre-operative x-ray(s)

Reimbursement includes local anesthesia.

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	19 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	19 and older	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	19 and older	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	19 and older	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	19 and older	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**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)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), 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	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	19 and older		No	One of (D4355) per 1 Lifetime Per patient.	
D4910	periodontal maintenance procedures	19 and older		Yes	Four of (D4910) per 12 Month(s) Per patient. 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy not to be combined with D1110 or D1120	pre-op x-ray(s), perio charting

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a fixed prosthesis may be considered when there is one missing maxillary anterior tooth or two missing mandibular anterior teeth and the member's overall status would justify consideration.

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

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

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	19 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	19 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	19 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	19 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	19 and older		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	19 and older		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	19 and older		Yes	One of (D5211, D5213, D5282, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	19 and older		Yes	One of (D5212, D5214, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	19 and older		Yes	One of (D5211, D5212, D5213, D5214, D5282, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	19 and older		Yes	One of (D5211, D5212, D5213, D5214, D5282, D5283, D5284, D5286) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5410	adjust complete denture - maxillary	19 and older		No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	19 and older		No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	19 and older		No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	19 and older		No	Not covered within 6 months of initial placement.	
D5511	repair broken complete denture base, mandibular	19 and older		No		
D5512	repair broken complete denture base, maxillary	19 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	19 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	19 and older		No		
D5612	repair resin partial denture base, maxillary	19 and older		No		
D5621	repair cast partial framework, mandibular	19 and older		No		
D5622	repair cast partial framework, maxillary	19 and older		No		

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken retentive/clasping materials per tooth	19 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	19 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	19 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5660	add clasp to existing partial denture	19 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D5710	rebase complete maxillary denture	19 and older		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5720	rebase maxillary partial denture	19 and older		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5721	rebase mandibular partial denture	19 and older		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5730	reline complete maxillary denture (chairside)	19 and older		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5731	reline complete mandibular denture (chairside)	19 and older		No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5740	reline maxillary partial denture (chairside)	19 and older		No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5741	reline mandibular partial denture (chairside)	19 and older		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	19 and older		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5751	reline complete mandibular denture (laboratory)	19 and older		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5760	reline maxillary partial denture (laboratory)	19 and older		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5761	reline mandibular partial denture (laboratory)	19 and older		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of placement by same dentist or dental group.	
D5850	tissue conditioning, maxillary	19 and older		No		
D5851	tissue conditioning,mandibular	19 and older		No		

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

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

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6211	pontic-cast base metal	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6212	pontic - cast noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6214	Pontic - titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6240	pontic-porcelain fused-high noble	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6241	pontic-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6242	pontic-porcelain fused-noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6243	Pontic - Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6545	retainer - cast metal fixed	19 and older	Teeth 1 - 32	Yes	One of (D6545, D6548) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	19 and older	Teeth 1 - 32	Yes	One of (D6545, D6548) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6740	retainer crown – porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6750	crown-porcelain fused high noble	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6751	crown-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6752	crown-porcelain fused noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6780	crown-3/4 cst high noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6790	crown-full cast high noble	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6791	crown - full cast base metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	One of (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	19 and older		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
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		
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	No	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
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	Third molar extractions must be symptomatic or show evidence of pathology. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	Third molar extractions must be symptomatic or show evidence of pathology. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	Third molar extractions must be symptomatic or show evidence of pathology. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	19 and older	Teeth 1 - 32, 51 - 82	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Third molar extractions must be symptomatic or show evidence of pathology. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
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	Will not be paid to the dentist or dental group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	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		pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	19 and older	Teeth 1 - 32	Yes	Includes splinting and/or stabilization.	pre-operative x-ray(s)
D7280	Surgical access of an unerupted tooth	19 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
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	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant performed on the same day. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op 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	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant performed on the same day. Covered only in conjunction with the construction of a prosthodontic appliance.	narr. of med. necessity, post-op x-ray(s)
D7471	removal of exostosis - per site	19 and older	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, post-op x-ray(s)
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		narrative of medical necessity
D7910	suture small wounds up to 5 cm	19 and older		Yes		narrative of medical necessity

Exhibit B Benefits Covered for DentaTrust/DentaSpan - 19 and Over

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7921	Collection and application of autologous blood concentrate product	19 and older		No	One of (D7921) per 36 Month(s) Per patient.	
D7971	excision of pericoronal gingiva	19 and older	Teeth 1 - 32	Yes		narrative of medical necessity

Exhibit B Benefits Covered for
DentaTrust/DentaSpan - 19 and Over

Reimbursement includes local anesthesia.

General anesthesia and IV sedation will be received on a case by case basis for medical necessity.

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	19 and older		No		
D9222	deep sedation/general anesthesia first 15 minutes	19 and older		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		Yes	Four of (D9223) per 1 Day(s) Per patient. Not to exceed 60 minutes or 4 units. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	19 and older		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		Yes	Four of (D9243) per 1 Day(s) Per patient. Not to exceed 60 minutes or 4 units. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19 and older		No		
D9610	therapeutic drug injection, by report	19 and older		Yes	One (D9610) per 1 Day(s) per patient. Description and dosage of drug and narrative of medical necessity.	narrative of medical necessity
D9613	infiltration of sustained release therapeutic drug--single or multiple sites	19 and older		Yes	One of (D9613) per 1 Day(s) Per patient. Allowed only with impaction removal of 1,16,17,32.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	19 and older		Yes		narrative of medical necessity