



DentaQuest USA Insurance Company, Inc.

Office Reference Manual

Driscoll Children's Health Plan

STAR Adults

Age 21 and older

Hidalgo & Nueces Service Area

Hidalgo: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata County

Nueces: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, and Victoria County

STAR Pregnant Women

Age 21 and older

Hidalgo & Nueces Service Area

Hidalgo: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata County

Nueces: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, and Victoria County

CHIP Perinate Pregnant Women Age

19 and older

Nueces Service Area

Nueces: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, and Victoria County

11044 Research Blvd.

Austin, TX 78759

888.308.9345

www.dentaquest.com

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**DentaQuest USA Insurance Company, Inc.
Address and Telephone Numbers**

**DentaQuest Provider Services:
888.308.9345**

Fax numbers:

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

Claims Questions:

txclaims@dentaquest.com

Customer Service/Member Services:

**DentaQuest (Driscoll) Member Services:
888.308.2950**

Driscoll Member Services:

**STAR (Medicaid) Nueces Service Area :
877.220.6376
STAR (Medicaid) Hidalgo Service Area:
855.425.3247
CHIP Nueces Service Area:
877.451.5598**

TTY Service: 800.855.2880

Credentialing applications should be sent to:

DentaQuest- Credentialing
PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Claims should be sent to:

Claims should be sent to:

DentaQuest -Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:

Direct entry on the web – www.dentaquest.com
Or,
Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentalQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

DentaQuest USA Insurance Company, Inc.

Statement of Member's Rights and Responsibilities

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and primary care provider. This is the dental provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any dental plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care dentist.
 - d. Change your dental plan without penalty.
 - e. Be told how to change your dental plan or your dental provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your dental care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with your provider in deciding what dental care is best for you.
 - b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint process through DentaQuest and through Medicaid, and get a timely response to complaints. That includes the right to:
 - a. Make a complaint to DentaQuest or to the state Medicaid program about your health care, your provider or your health plan.
 - b. Get a timely answer to your complaint.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b. Get dental care in a timely manner.
 - c. Be able to get in and out of a dental provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

- d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
 - e. Be given information you can understand about DentaQuest plan rules, including the dental services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
 8. You have a right to know that dentists and others who care for you can advise you about your dental care, and treatment. DentaQuest cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
 9. You have a right to know that you are not responsible for paying for covered services. Dentists and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - a. Learn and understand your rights under the Medicaid program.
 - b. Ask questions if you do not understand your rights.
 - c. Learn what choices of health plans are available in your area.
2. You must abide by DentaQuest and Medicaid's policies and procedures. That includes the responsibility to:
 - a. Learn and follow DentaQuest's rules and Medicaid rules.
 - b. Choose your dental plan and a primary care dentist quickly.
 - c. Make any changes in your dental plan and primary care dentist in the ways established by Medicaid and by DentaQuest.
 - d. Keep your scheduled appointments.
 - e. Cancel appointments in advance when you cannot keep them.
 - f. Always contact your primary care dentist first for your non-emergency dental needs.
 - g. Be sure you have approval from your primary care dentist before going to a specialist.
 - h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your dentist and learn about service and treatment options. That includes the responsibility to:
 - a. Tell your dentist about your health.
 - b. Talk to your providers about your dental needs and ask questions about the different ways your dental problems can be treated.
 - c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
 - a. Work as a team with your provider in deciding what health care is best for you.
 - b. Understand how the things you do can affect your health.
 - c. Do the best you can to stay healthy.
 - d. Treat providers and staff with respect.

DentaQuest USA Insurance Company, Inc.

Statement of Provider Rights and Responsibilities

Providers shall have the right and responsibility 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 DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with a complaint filed by the Member.
5. Object to policies, procedures, or decisions made by DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.
7. To be informed of the status of their credentialing or recredentialing application, upon request.
8. Verify member eligibility, benefits and authorizations required for services to be performed.

* * *

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
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1.00 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

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

1.02 Member Identification Card

Members will receive a Plan ID Card. 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.

Sample of Driscoll Children’s Health Plan ID Cards:



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

Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the anticipated date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on "Dentist". From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 800.341.8478. Once logged in, select "select patient from the portal menus then choose member eligibility search". 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. **Be sure to verify eligibility on the date of service.** Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department at 888.308.9345 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member the Member's recipient identification number and date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service at 888.308.9345.
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, enter you're NPI (National Provider Identification number).
5. When prompted, enter the last four (4) digits of your Tax ID number.
6. Does the member's ID **only have numbers** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **numbers and letters** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888.308.9345. They will be able to assist you in utilizing either system.

1.04 Specialist Referral Process

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

2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

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

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see section 13). 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 provider begins (Non-Emergency) treatment.

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

Your submission of “documentation” should include:

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

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

The authorization number will be provided within two business days from the date the documentation is received. Authorization 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. Claims sent without this “documentation” will be denied.

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.

2.02 Payment for Non-Covered Services

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

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

2.03 Electronic Attachments

- A. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

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

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at:

800.782.5150

3.00 Provider Complaints and Appeals Procedure

Medicaid Complaint- means an expression of dissatisfaction expressed by a member, orally or in writing to DentaQuest, about any matter other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

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

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

Complaints to DentaQuest may be submitted using the following methods:

(non-claim related) • By telephone at 1-888.308.9345

(Claim related) • In writing to:

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

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

Medicaid complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X
PO Box 204077
Austin, TX 78720-4077

CHIP complaint requests may be mailed to the following address:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

Provider Claim Appeals

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

4.00 Claim Submission Procedures (claim filing options)

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.

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

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

4.02 Electronic Claim Submission Utilizing DentaQuest’s Internet Website

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

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State’ and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 800.341.8478. 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.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 800.341.8478. 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-Claims
12121 N. Corporate Parkway
Mequon, WI 53092**

4.08 Coordination of Benefits (COB)

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

4.09 Filing Limits

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

4.10 Receipt and Audit of Claims

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

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

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 **or**
 - Via Mail -

DentaQuest USA Insurance Company, Inc.
12121 North Corporate Parkway
Mequon, WI 53092
ATTN: PEC 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 Direct Deposit 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 Dentist Portal. Providers may access their remittance statements by following these steps:

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

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-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 Customer Service department at 888.308.9345 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

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

6.00 Utilization Management Program (Policies 500 series)

6.01 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.

6.02 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.

6.03 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.

6.04 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.

7.00 Fraud and Abuse (Policies 700 Series)**Reporting Waste, Abuse or Fraud by a Provider or Member Medicaid Managed Care and CHIP****Do you want to report Waste, Abuse, or Fraud?**

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG hotline at 1-800-436-6184
- Visit <https://oig.hhsc.state.tx.us/> and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form or
- You can report directly to your health plan:

DentaQuest-TX HHSC Dental Services
Attention: Utilization Review Department
12121 North Corporate Parkway
Mequon, WI 53092

Toll free at 1-800-237-9139

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
 - Name, address, and phone number of provider
 - Name and address of the facility (hospital, nursing home, home health agency, etc.)
 - Medicaid number of the provider and facility, if you have it Type of provider (doctor, dentist, therapist, pharmacist, etc.)
 - Names and phone numbers of other witnesses who can help in the investigation
 - Names and phone numbers of the other witnesses who can help with the investigation
 - Dates of events
 - Summary of what happened
- When reporting about someone who gets benefits include:
 - Dates of events
 - Summary of what happened
 - The person's name, date of birth, Social Security number or case number if you have it
 - The city where the person lives
 - Specific details about the waste, abuse or fraud.

To report suspected fraud or abuse, please contact DentaQuest at 1.800.237.9139. or write to:

Utilization Review Department
DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092

Providers may also send a fax to: 262.241.7366

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

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 888.308.9345 or via e-mail at:

denelig.benefits@dentaquest.com

9.00 Credentialing (Policies 300 Series)

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

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

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

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

Appeal of Credentialing Committee Recommendations. (Policy 300.017)

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

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

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Re-credentialing (Policy 300.016)

Network Providers are re-credentialed at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service department at 888.308.9345 or via e-mail at denelig.benefits@dentaquest.com.

10.00 The Patient Record

A. Organization

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

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

1. Adequate documentation of registration information which requires entry of these items:
 - a. Patient's first and last name.
 - b. Date of birth.
 - c. Sex.
 - d. Address.
 - e. Telephone number.
 - f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:
 - a. Current medical treatment.
 - b. Significant past illnesses.
 - c. Current medications.
 - d. Drug allergies.
 - e. Hematologic disorders.
 - f. Cardiovascular disorders.
 - g. Respiratory disorders.
 - h. Endocrine disorders.
 - i. Communicable diseases.
 - j. Neurologic disorders.
 - k. Signature and date by patient.
 - l. Signature and date by reviewing dentist.
 - m. History of alcohol and/or tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
 - a. Significant changes in health status.
 - b. Current medical treatment.
 - c. Current medications.
 - d. Dental problems/concerns.
 - e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
 - a. Health problems which contraindicate certain types of dental treatment.
 - b. Health problems that require precautions or pre-medication prior to dental treatment.
 - c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
 - d. Drug sensitivities.
 - e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.
 - c. Soft tissue examination.
 - d. Periodontal assessment.
 - e. Occlusal classification.
 - f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.
 - c. Soft tissue examination.
 - d. Periodontal assessment.
 - e. Dentition charting.

7. Radiographs which are:
 - a. Identified by patient name.
 - b. Dated.
 - c. Designated by patient's left and right side.
 - d. Mounted (if intraoral films).
8. An indication of the patient's clinical problems/diagnosis.
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
 - a. Procedure.
 - b. Localization (area of mouth, tooth number, surface).
10. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
 - a. Periodontal pocket depth.
 - b. Furcation involvement.
 - c. Mobility.
 - d. Recession.
 - e. Adequacy of attached gingiva.
 - f. Missing teeth.
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
 - a. Gingival status.
 - b. Amount of plaque.
 - c. Amount of calculus.
 - d. Education provided to the patient.
 - e. Patient receptiveness/compliance.
 - f. Recall interval.
 - g. Date.
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
 - a. Provider to whom consultation is directed.
 - b. Information/services requested.
 - c. Consultant's response.
13. Adequate documentation of treatment rendered which requires entry of these items:
 - a. Date of service/procedure.
 - b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
 - c. Type and dosage of anesthetics and medications given or prescribed.

- d. Localization of procedure/observation. (tooth #, quadrant etc.)
 - e. Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:
- a. Patient examination.
 - b. Treatment plan.
 - c. Treatment status.

C. Compliance

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

11.00 Patient Recall System Requirements

A. Recall System Requirement

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

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

- A. "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."
- B. "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.

- C. Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- D. 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

- E. In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- F. DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- G. Urgent care must be available within 48 hours.
- H. Emergency care must be available within 24 hours.

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

12.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations

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

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

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

3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

The Panel recommends an individualized radiographic examination consisting of selected 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.

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.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

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

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

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology 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.

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

date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

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

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/obtured. 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 Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

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

All Operating Room (OR) Cases Must be Authorized.

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should contact health plan for facility authorization. Refer to Section 3.00 for telephone numbers.

Criteria

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

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, resent

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

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

13.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

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

Criteria

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

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

in the fee for the removable prosthetic and as such not eligible for additional compensation.

The replacement teeth should be anatomically full sized teeth.

Authorizations for removable prosthesis will not meet criteria:

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

Criteria

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

- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

13.07 Criteria for the Excision of Bone Tissue

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

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

Authorization requirements:

- 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.

13.08 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

13.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

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

Criteria

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

13.10 Criteria for Short Procedure Units (SPU)

Documentation needed to authorization of procedure:

- Radiographs.
- Treatment notes.
- Documentation of medical.

All SPU Cases Must be Authorized.

Criteria

Provider should submit services to DentaQuest for authorization. Upon receipt of approval for dental services from DentaQuest, Provider should contact Health Plan for facility authorization. Refer to Section 3.00 for telephone numbers.

In most cases, short procedures units will be approved (for procedures covered by health plan) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of abscesses, or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for example, poorly controlled hypertension, poorly controlled diabetes, upper respiratory infection, an arrhythmia, recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

13.11 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.

APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

- A. “Contract” means the document specifying the services provided by DentaQuest to:
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the Plan and DentaQuest;
 - a CHIP Perinate beneficiary directly or on behalf of a Plan, as agreed upon between the Plan and DentaQuest;
 - 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”).
- B. “Covered Services” is a dental service or supply that satisfies all of the following criteria:
- provided or arranged by a Participating Provider to a Member;
 - authorized by DentaQuest in accordance with the Plan Certificate; and
 - submitted to DentaQuest according to DentaQuest’s filing requirements.
- C. “DentaQuest” shall refer to DentaQuest USA Insurance Company, Inc.
- D. “DentaQuest Service Area” shall be defined as the agreed upon service area for the Plan.
- E. “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.
- F. “Member” means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a 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 CHIP Perinate Contract is referred to as a “CHIP Perinate Member.” A Member enrolled pursuant to a Medicare Contract is referred to as a “Medicare Member.”

- G. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members**
- H. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.**
- I. "Plan Certificate" means the document that outlines the benefits available to Members.**
- K. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.**
- L. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.**

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ www.dentaquest.com. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State’ and press go. You will then be able to log in using your password and User ID. Once logged in, select the link “Related Documents” to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam
- Recall Examination Form
- Authorization for Dental Treatment
- Medical and Dental History
- Direct Deposit Form
- Provider Change Form
- Request for Transfer of Records

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 888.308.9345.

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

ADA Dental Claim Form

HEADER INFORMATION																										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																										
2. Predetermination/Preauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																					
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																										
3. Company/Plan Name, Address, City, State, Zip Code																										
13. Date of Birth (MM/DD/CCYY)			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)																					
16. Plan/Group Number					17. Employer Name																					
OTHER COVERAGE																										
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																						
9. Plan/Group Number			10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																										
PATIENT INFORMATION																										
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other							19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																			
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																										
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																					
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										ANCILLARY CLAIM/TREATMENT INFORMATION																
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.										38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																
X Patient/Guardian signature _____ Date _____										39. Number of Enclosures (00 to 99) Radiograph(s) _____ Oral Image(s) _____ Model(s) _____																
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/CCYY)											
X Subscriber signature _____ Date _____										42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date Prior Placement (MM/DD/CCYY)						
48. Name, Address, City, State, Zip Code										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																
49. NPI										46. Date of Accident (MM/DD/CCYY)					47. Auto Accident State											
50. License Number										49. NPI																
51. SSN or TIN										55. License Number																
52. Phone Number () - -										56. Address, City, State, Zip Code																
52A. Additional Provider ID										56A. Provider Specialty Code																
57. Phone Number () - -										58. Additional Provider ID																
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 _____																



American Dental Association
www.ada.org

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

GENERAL INSTRUCTIONS

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

COORDINATION OF BENEFITS (COB)

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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
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INITIAL CLINICAL EXAM

PATIENT'S NAME _____

<div style="display: flex; justify-content: space-between; font-size: small;"> Last First Middle </div>	<p>GINGIVA</p> <hr/> <p>MOBILITY</p> <hr/> <p>PROTHESIS EVALUATION</p> <hr/> <p>OCCUSION 1 11 111</p> <hr/> <p>PATIENT'S CHIEF COMPLAINT</p>
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<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:80%;"></td><td style="width:20%; text-align: center;">OK</td></tr> <tr><td>LYMPH NODES</td><td></td></tr> <tr><td>PHARYNX</td><td></td></tr> <tr><td>TONSILS</td><td></td></tr> <tr><td>SOFT PALATE</td><td></td></tr> <tr><td>HARD PALATE</td><td></td></tr> <tr><td>FLOOR OF MOUTH</td><td></td></tr> <tr><td>TONGUE</td><td></td></tr> <tr><td>VESTIBULES</td><td></td></tr> <tr><td>BUCCAL MUCOSA</td><td></td></tr> <tr><td>LIPS</td><td></td></tr> <tr><td>SKIN</td><td></td></tr> <tr><td>TMJ</td><td></td></tr> <tr><td>ORAL HYGIENE</td><td></td></tr> <tr><td>PERIO EXAM</td><td></td></tr> </table>		OK	LYMPH NODES		PHARYNX		TONSILS		SOFT PALATE		HARD PALATE		FLOOR OF MOUTH		TONGUE		VESTIBULES		BUCCAL MUCOSA		LIPS		SKIN		TMJ		ORAL HYGIENE		PERIO EXAM		<p style="text-align: center;">CLINICAL FINDINGS/COMMENTS</p>
	OK																														
LYMPH NODES																															
PHARYNX																															
TONSILS																															
SOFT PALATE																															
HARD PALATE																															
FLOOR OF MOUTH																															
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LIPS																															
SKIN																															
TMJ																															
ORAL HYGIENE																															
PERIO EXAM																															
RADIOGRAPHS	B/P	RDH/DDS																													

RECOMMENDED TREATMENT PLAN			
TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST _____ DATE _____

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

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

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

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

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

COMMENTS: _____

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

Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

Yes No If

yes, please list: _____

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

Do your ankles swell during the day? Yes No

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

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

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

Are you on a special diet? Yes No

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

If yes, where? _____

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

yes, how often and how much? _____

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

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

Yes No

If yes, please list: _____

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

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

For Women Only:

Are you pregnant?

Yes No

If yes, what month? _____

Are you nursing?

Yes No

Are you taking birth control pills?

Yes No

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

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

REVIEW DATE	Changes in Health Status	Patient's signature	Dentist's signature

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 USA-TX HHSC Dental Services Program**

INSTRUCTIONS

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

MAINTENANCE TYPE:

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

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____ Checking
_____ Personal _____ Business (choose one)

Bank Routing Number:

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

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

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

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

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

Date

Print Name

Phone Number

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

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

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

Provider Change Form

Provider Name _____

Provider NPI _____

Tax ID _____

Location Address _____ **GID #** _____

Location Address _____ **GID#** _____

Location Address _____ **GID#** _____

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

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

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

888.308.9345, 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 and. These codes must be referenced in the patient's file for record retention and review. All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

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

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

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

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:

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

When documentation is requested “with claim:”

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

**Exhibit A Benefits Covered for
TX Driscoll STAR Pregnant Women & CHIP Perinate**

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

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

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

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

All radiographs must be of 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.

CHIP Perinate members are 19 and older and Star Pregnant Women are 21 and older.

Up to \$500 in dental services for pregnant members. Includes routine checkups, 2 dental cleanings every 6 months, xrays, 1 gum treatment, fillings.

When looking at the age limitations, please keep this in mind.

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) per 12 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	19 and older		No	One of (D0150) per 1 Lifetime Per Provider.	
D0210	intraoral - comprehensive series of radiographic images	19 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	19 and older		No		
D0230	intraoral - periapical each additional radiographic image	19 and older		No		
D0272	bitewings - two radiographic images	19 and older		No	One of (D0272, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	19 and older		No	One of (D0272, D0274) per 12 Month(s) Per patient.	
D0330	panoramic radiographic image	19 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	

**Exhibit A Benefits Covered for
TX Driscoll STAR Pregnant Women & CHIP Perinate**

CHIP Perinate members are 19 and older and Star Pregnant Women are 21 and older.

When looking at the age limitations, please keep this in mind.

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	Two of (D1110) per 12 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	

**Exhibit A Benefits Covered for
TX Driscoll STAR Pregnant Women & CHIP Perinate**

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
D2330	resin-based composite - one surface, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	19 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit A Benefits Covered for
TX Driscoll STAR Pregnant Women & CHIP Perinate**

CHIP Perinate members are 19 and older and Star Pregnant Women are 21 and older.

When looking at the age limitations, please keep this in mind.

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
D4341	periodontal scaling and root planing - four or more teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341) per 12 Month(s) Per patient per quadrant.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	19 and older		No	One of (D4346, D4355) per 12 Month(s) Per patient. Not allowed for 12 months following D1110 or D4341.	

**Exhibit A Benefits Covered for
TX Driscoll STAR Pregnant Women & CHIP Perinate**

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	No		

**Exhibit B Benefits Covered for
TX Driscoll STAR**

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

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

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

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

All radiographs must be of 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.

Dental Care for Adults: Up to \$500 in dental services per year for adult members. Services include routine checkups, 2 teeth cleanings, xrays, 1 gum treatment included, and fillings.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 12 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Provider.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	21 and older		No		
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider OR Location.	

**Exhibit B Benefits Covered for
TX Driscoll STAR**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 12 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	

**Exhibit B Benefits Covered for
TX Driscoll STAR**

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
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit B Benefits Covered for
TX Driscoll STAR**

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
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341) per 12 Month(s) Per patient per quadrant.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D4346, D4355) per 12 Month(s) Per patient. Not allowed for 12 months following D1110 or D4341.	

**Exhibit B Benefits Covered for
TX Driscoll STAR**

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82	No		