INTRODUCTION

Addresses and Telephone Numbers

DentaQuest Customer Service
Member Services: 855.418.1622
Provider Services: 855.418.1623

11100 Liberty Drive
Milwaukee, WI 53224

Fax numbers:
- Claims/payment issues: 262.834.7379
- Claims to be Reprocessed: 262.834.3589
- All other: 262.834.3450

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

TDD/TTY (Hearing Impaired)
711 800.466.7566

Special Needs Member Services
800.660.3397

ECF CHOICES TennCare Fraud Hotline
800.433.3982

Web Site
www.dentaquest.com

State of Tennessee
ECF CHOICES
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
http://www.tn.gov/tenncare/

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

Treatment Plans should be sent to:
ECFChoicesTN@greatdentalplans.com
for authorization

Fax: 262.241.7150 or 888.313.2883
ECFChoicesTN@greatdentalplans.com

Outpatient/Hospital
Fax: 262.834.3575

Dental claims should be sent to:
DentaQuest – ECF CHOICES Claims
PO Box 2906
Milwaukee, WI 53201-2906

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

Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.834.3452
Email: ComplaintsandGrievances@dentaquest.com

TennCareSM Legal Solutions Unit
P.O. Box 000593
Nashville, TN 37202-0593
800.878.3192

ECF CHOICES MEMBER Language Information Line(s)

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<tr>
<th>Language</th>
<th>Toll Free Number</th>
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<tbody>
<tr>
<td>Arabic</td>
<td>1-800-758-1638</td>
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<td>Bosnian</td>
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<td>Vietnamese</td>
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ECF CHOICES ORM 06062017
Program Objective

The primary objective of the Employment and Community First CHOICES (ECF CHOICES) Medicaid Dental program is to create a comprehensive dental care system offering quality dental Covered Services that are Medically Necessary to eligible Tennessee residents. We emphasize early intervention and promote access to necessary dental care, thereby improving health outcomes for Tennessee residents.

We connect with Members to stress that preventive care is one of the best ways to achieve good oral and overall health. We saturate this message to Members and their parents/guardians by employing multiple communication channels.

- Provider directory
- Welcome packets
- Through providers via prevention-based programs, provider web portal and provider newsletters

Medically Necessary Covered Services

DentaQuest is responsible for administering ECF CHOICES covered dental benefits as medically necessary for Medicaid eligible Members who are enrolled in the ECF CHOICES program. A comprehensive list of the Covered Service codes can be found in Exhibit A of this manual. DentaQuest must provide coverage in a manner which satisfies all regulatory rules and regulations established through Tennessee’s Medicaid Managed Care Program by The State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare.
# Office Reference Manual

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1.00 General Information

1.01 Member Rights and Responsibilities

A. Introduction

The mission of DentaQuest is to expand access to high-quality, medically necessary, and compassionate health care services within the allocated resources. DentaQuest is committed to ensuring that all ECF CHOICES Program Members are treated in a manner that respects their rights and acknowledges Members’ responsibilities. Members have the right to receive medical services and have certain responsibilities to aid in receiving them in accordance with TennCareSM Rules 1200-13-01 et seq. The following is a statement of Member Rights and Responsibilities.

B. Member Rights

Member rights include but are not limited to the following:

1. To be treated with respect and recognition of their dignity and need for privacy;

2. To be provided with information about the organization, its services, the practitioner providing care, and Member rights and responsibilities;

3. To be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;

4. To participate in decision-making regarding their dental care;

5. To voice complaints or appeals about the organization or care provided;

6. To be guaranteed the right to request and receive a copy of his or her dental records and to request that they be amended or corrected as specified in 45CFR part 164;

7. To be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

8. To be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Dental Benefits Manager (DBM) and its providers or The State agency treat the Member, and;

9. To be guaranteed the right to receive information on available
treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.

Additional Member rights are as follows:

**Confidentiality**

All dental information about ECF CHOICES Members is confidential. Members have the right to be treated with respect and recognition of their dignity and need for privacy when receiving their dental care. Provider and DentaQuest will ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization. Provider and DentaQuest shall hold confidential all information obtained by its personnel about Members related to their examination, care and treatment and shall not divulge it without the Member's authorization, unless:

- It is required by law;
- It is necessary to coordinate the Member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
- It is necessary in compelling circumstances to protect the health or safety of an individual.

Release of information shall be reported to the Member prior to disclosure to give the Member sufficient time to object should the Member wish to. Member records may be disclosed, whether or not authorized by the Member, to qualified personnel for the purpose of conducting scientific research that has been approved by an Institutional Review or Privacy Board, but these personnel may not identify, directly or indirectly, any individual Member in any report of the research or otherwise disclose participant identity in any manner.

DentaQuest and the Provider shall ensure all materials and information directly or indirectly identifying any current or former Member which is provided to or obtained by or through DentaQuest’s performance of its contract with TennCare, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated (T.C.A.), Title 42, Part 2, Code of Federal Regulations, the Privacy Act of 1974, 5 USC 552a, the Medicaid regulations, 42 Code of Federal Regulations 431.300 et seq., IRC Section 6103(p), and the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”) as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to TennCare, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees.
**Informed Consent**
A Member’s consent is required for all treatment, unless there is an emergency and the Member’s life is in serious danger. Members have the right to participate in decisions regarding their health, including consent to have invasive treatment. If written consent is required for special procedures, such as surgery, Members must understand the procedure and why it is advised. Should Members not want a particular treatment, they have the right to discuss their objections with their Provider, who will advise and discuss options. The final decision is up to the Member.

**Emergency Services**
A member can access a DentaQuest dentist for emergencies 24 hours a day, seven days a week. An enrollee should ask their provider how to contact him or her in an emergency. Their provider may have a different telephone number to call in an emergency.

**Dental Records**
Members have the right to request access to their dental records as provided by State and federal laws. When transferring to another dental provider, Members have the right to request access to their dental records free of charge.

Members have the right to request restriction of uses and disclosures. Provider must accommodate reasonable requests by Members to receive communications of PHI from the provider by alternative means or at alternative locations.

Provider must permit Members to request that the provider amend the PHI in the Member’s record. Provider may require that Members make the request in writing and provide a reason to support a requested amendment.

Members have the right to receive an accounting of disclosures in the six (6) years prior to the date the Member requests the accounting.

For the most up to date and detailed information regarding HIPAA and Member rights go to [http://www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/index.html)

**Discrimination**
Members have the right not to be discriminated against by their health care Provider on the basis of their age, sex, race, color, religion, physical or mental disability, national origin, economic status or payment source, type/degree of illness or condition, or any other classification protected by federal and state laws and regulations.
Providers shall agree to cooperate with ECF CHOICES and DentaQuest during discrimination complaint investigations. In addition, the Provider must assist ECF CHOICES enrollees in obtaining discrimination complaint forms and assistance from DentaQuest with submitting the forms to TennCare. A copy of the Complaint form and notice of fair treatment can be found online; see Appendix A of this document for a full list of forms.

DentaQuest and the Provider shall comply with Title III of the Americans with Disabilities Act of 1990 in the provision of equal opportunities for enrollees with disabilities. In the event that a reasonable modification or effective communication assistance in alternative formats for an enrollee is not readily achievable by the Provider, DentaQuest shall provide the reasonable modification or effective communication assistance in alternative formats for the enrollee unless DentaQuest can demonstrate that the reasonable modification would impose an undue burden on DentaQuest.

Auxiliary aids and services are available under Title III of the ADA and Section 504 of the Rehabilitation Act of 1973. For more guidance see: www.ada.gov; http://www.ada.gov/taman3.html; and http://www.hhs.gov/ocr/civilrights/resources/laws/index.html

**Non-Discrimination Compliance Offices**

Contact information for non-discrimination compliance offices are as follows:

**Bureau of TennCare**

- **Phone:** 615.507.6474
- **E-mail:** TennCare.fairtreatment@tn.gov

You can also write to:

The Office of Non-discrimination Compliance/Health Care Disparities
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: 615.253.2917
TDD: Toll Free 1.800.772.7647
Local: 313.9240

**DentaQuest**

- **Phone:** 262.834.3576
- **E-mail:** DentaQuest.fairtreatment@dentaquest.com
You can also write to:

Non-discrimination Compliance Coordinator  
DentaQuest of Tennessee, LLC  
PO Box 2906  
Milwaukee, WI  53201-2906  
Fax: 800.241.7366  
TDD: Toll Free 1.800.417.7140 ext. 43576  
Local 262.834.3576

**Language Assistance Services**

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at which the request for service is received. The Executive Order, signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to TennCare℠ and it is not permissible to charge an ECF CHOICES Member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found on line at [http://www.justice.gov/crt/about/cor/coord/titlevi.php](http://www.justice.gov/crt/about/cor/coord/titlevi.php).

Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of TennCare℠ Members. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found on line at [http://www.lep.gov/ISpeakCards2004.pdf](http://www.lep.gov/ISpeakCards2004.pdf).

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers cannot locate interpreters specializing in meeting needs of LEP clients by calling the translation numbers listed at the front of this guide.

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.
Advance Directives
Members have the right to determine their treatment by issuing advance directives (legal provisions that allow their wishes to be carried out when they are incapable of making important health decisions). These directives may include:

- A living will to express the Member’s wishes concerning life-sustaining treatment by artificial means when terminally ill;
- A durable power of attorney for health care that gives an individual appointed by the Member the authority to make decisions regarding the Member’s treatment; or
- Nominating a guardian or conservator, a court-appointed individual who represents the Member’s interests when he/she is unable to make independent decisions.

Member Appeals
Members shall have the right to file appeals regarding adverse actions taken by DentaQuest or the Provider. The term “Appeal” shall mean a Member’s right to contest verbally or in writing, any “Adverse Benefit Determination” taken by DentaQuest or the Provider to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of DentaQuest or the Provider that impair the quality, timeliness, or availability of such benefits. An Appeal may be filed by the Member or by a person authorized by the Member to do so, including but not limited to, a Provider with the Member's consent. DentaQuest shall inform Members of their Appeal rights in the Member Handbook. See section 7.00 of this manual for specific Appeal guidelines.

Member Grievance
A Member “Grievance” shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does NOT meet the definition of Adverse Benefit Determination. For example, a Complaint may arise due to how the Member was treated by the Provider or the Provider’s staff during an office visit (i.e. rude or inappropriate behavior or not answering the Member’s questions) or if the Member feels that a DentaQuest staff Member treated him/her inappropriately (i.e. being rude during a phone call, or not returning a Member’s phone calls). DentaQuest shall inform Members of their Grievance rights in the Member Handbook. ECF CHOICES takes Member’s Complaints very seriously and requires DentaQuest and DentaQuest’s Providers to do the same. See section 7.03 of this manual for specific guidelines pertaining to handling Member Grievances.
Information
Members have the right to be provided with information about the services offered by DentaQuest, or the dental practitioner providing the care and their own personal rights and responsibilities.

C. Member Responsibilities

Enrollment in the ECF CHOICES program carries certain Member responsibilities. While all Members receive a handbook that details those responsibilities, Providers are also encouraged to familiarize themselves with Member responsibilities. Those responsibilities include:

- Knowing and understanding the terms, conditions and provisions of the ECF CHOICES program and DentaQuest and abiding by them.
- Following preventive health guidelines, prescribed treatment plans and guidelines given by those providing health care services.
- Scheduling or rescheduling appointments and informing the Provider when it is necessary to cancel an appointment.
- Showing member’s MCO ID card whenever receiving health care or prescription medication.
- Providing, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health services.
- Closely following the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
- Participating in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

1.02 Provider Rights and Responsibilities

A. DentaQuest Participating Providers have a right to:

- Receive information about the ECF CHOICES program, its services, and its Members’ rights and responsibilities.
- Be informed of the status of their credentialing or re-credentialing application, upon request.
• Object to rules, policies, procedures, or decisions of DentaQuest or ECF CHOICES, as set forth in this document and the provider agreement.

• File an appeal as delineated in this Provider Office Reference Manual.

• Not be discriminated against with regard to participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

• Not be discriminated against for specializing in conditions that require costly treatment.

• Recommend a course of treatment to a Member, even if the course of treatment is not a Covered Service or approved by ECF CHOICES. However, the Provider must inform the Member that ECF CHOICES will only pay for covered services that are medically necessary that the Member is eligible to receive under the ECF CHOICES program.

• Communicate with Members regarding dental/treatment options.

• Specify the functions and/or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional practice. However, ECF CHOICES will only pay for covered services that are medically necessary that the Member is eligible to receive under the ECF CHOICES program.

• Discontinue treatment of a Member with whom the practitioner feels he/she cannot establish or maintain a professional relationship.

B. ECF CHOICES Participating Providers have the responsibility to:

• Screen all employees and contractors to determine whether any of them have been excluded from participation as a Medicaid provider. This obligation is a condition of a Provider’s enrollment as a Medicaid provider and is also a continuing obligation during a Provider’s entire term as such. Provider acknowledges that as a Medicaid provider, Provider is required and agrees to search the Health and Human Services Office of Inspector General (HHS-OIG) website monthly to learn of persons who have been excluded and reinstated as Medicaid providers. Provider is required and agrees to immediately report any exclusion information discovered relating to its employees or contractors to DentaQuest. The National Practitioner Data Bank (NPDB) is a federal data bank which was created to serve as a repository of information about health care providers in the United States. NPDB can be used a source of data to obtain any exclusions reported regarding a given provider.
• Recognize and abide by all applicable State and Federal laws, regulations, rules, policies, court orders and guidelines and the requirements of the Provider Agreement, its attachments, and this DentaQuest Office Reference Manual (ORM). This includes monthly checks of the Providers’ employees and contractors against the federal U.S. Department of Health and Human Services’ Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) database for excluded providers.

• The provider shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, the Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (TBI MFCU), Department of Health and Human Services Office of the Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, or their designees, access to their records. Said records shall be made available at no cost to the requesting party and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, ECF CHOICES or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCU, the DHHS OIG and the DOJ or their designees;

• Assist in such reviews including the provision of complete copies of dental records.

• Provide at no cost to a Member or Member’s new dental Provider all dental/medical records, when care is being transferred to another dentist.

• Allow participation by the Member in the decision-making regarding the Member’s dental care.

• Discuss appropriate or medically necessary treatment options for the Member’s conditions, regardless of cost or benefit coverage. However, ECF CHOICES will only pay for covered services that are medically necessary that the Member is eligible to receive under the ECF CHOICES program.

• Provide information that ECF CHOICES and DentaQuest require to evaluate the quality of care and service.

• Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.

• Serve as a conduit to the practitioner community regarding the dissemination of health care information.
- Notify Member in writing if a recommended service or supply is not a Medically Necessary Covered Service and obtain a written waiver from the Member prior to rendering such service that indicates the Member was aware that such service or supply is not a Medically Necessary Covered Service and that the Member agrees to pay for such service or supply if provided.

- Abide by the accessibility and availability standards as set forth in Section 3 of the Provider Agreement.

- Ensure that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.

- Offer hours of operation that are not less than the hours of operation offered to commercial enrollees and ensure that the office waiting time shall not exceed forty-five (45) minutes.

- Make Member appeal forms available at the service site. Display notices of Member’s right to appeal Adverse Benefit Determinations affecting services in public areas of their facility(s). DentaQuest shall ensure that the providers have the correct and adequate supply of public notices. The Notice must be displayed in a conspicuous location (i.e. waiting room, check-in window, check-out window).

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

- Ensure that ECF CHOICES is the payer of last resort. Thus, Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim to DentaQuest for payment by TennCare.

- Document services declined by a parent, guardian or mature competent enrollee and specify the service declined.

2.00 Member Eligibility Verification

2.01 State Eligibility System

The State of Tennessee provides the most up-to-date on line eligibility access through TennCare Online Services. For instructions, please go to https://tcmisweb.tenncare.tn.gov/tcmis/tennessee/Security/logon.asp

2.02 DentaQuest Eligibility System

DentaQuest does not issue eligible Members ID cards. Cards are often out of date or lost by Members. It is the Provider’s responsibility to check the databases available to confirm eligibility before providing services.
ECF CHOICES will only pay for covered services that are medically necessary and that the Member is eligible to receive under the ECF CHOICES program. If the Provider fails to verify that the Member is eligible for the services rendered and it is later determined that the Member was not eligible, ECF CHOICES will not pay the Provider for the services rendered, and the Provider may not collect or attempt to collect the cost of such services from the Member, except as provided in Section 2.04 below.

Participating Providers may access Member eligibility information through DentaQuest’s Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed via www.dentaquestgov.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest’s Customer Service department at 855-418-1623; 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 website currently allows Providers to verify a Member’s eligibility as well as submit claims directly to DentaQuest. You can verify the Member’s eligibility on-line by entering the Member’s date of birth, the expected date of service and the Member’s identification number or the Member’s full last name and first initial. To access the eligibility information via DentaQuest’s website, simply go to our website at www.dentaquestgov.com. Once you have entered the website, click on the “Dentist” icon. From there choose your “State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 855-418-1623. Once logged in, select “Patient” and then “Member Eligibility Search” and from there enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line
To access the IVR, simply call DentaQuest’s Customer Service Department at 855-418-1623. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, (i.e. Member history), which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid
or Medicare Member by entering your 6-digit DentaQuest location number, the Member’s recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient’s eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

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

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

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 855-418-1623. They will be able to assist you in utilizing either system.

2.03 Member Liability

Providers may seek payment from ECF CHOICES Members only in the following situations:

- If the services are not covered by the ECF CHOICES program and, prior to providing the services, the Provider informed the Member the services are not covered. The Provider is required to inform the Member of the non-covered service and have the Member acknowledge the information. If the Member still requests the service, the Provider shall obtain such acknowledgment in writing prior to rendering the service.
• If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the Member that the services are not covered, the Member may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

Providers may not seek payment from DentaQuest Members when:

• The Provider knew or should have known about the Member’s ECF CHOICES eligibility or pending eligibility prior to providing services.

• The claim(s) submitted to DentaQuest for payment was denied due to Provider billing error or a DentaQuest claims processing error.

• The Provider accepted DentaQuest assignment on a claim and it is determined that a primary plan paid an amount equal to or greater than the ECF CHOICES allowable amount.

• The Provider failed to comply with ECF CHOICES policies and procedures or provided a service that lacks Medical Necessity or justification.

• The Provider failed to submit or resubmit claims for payment within the time periods required by DentaQuest.

• The Provider failed to ascertain the existence of ECF CHOICES eligibility or pending eligibility prior to providing non-emergency services. Even if the Member presents another form of insurance, the Provider must determine whether the Member is covered under TennCare.

• The Provider failed to inform the Member prior to providing a service not covered by ECF CHOICES that the service was not covered and the Member may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations must always be discussed prior to providing service and billing Member.

• The Member failed to keep a scheduled appointment(s). If the provider has a fee for un-canceled, unattended visits, that must be covered upon enrollment with the provider, clearly stated, and signed off on by the member.
• The Provider failed to follow Utilization Management (UM) notification, Tennessee Dental Director, or prior authorization policies and procedures.

2.04 Coordination of Benefits

ECF CHOICES is the payer of last resort. Dental claims submitted to DentaQuest for payment by ECF CHOICES must be submitted to the primary dental insurance (when applicable) prior to submission to DentaQuest for payment.

Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim to DentaQuest for payment by ECF CHOICES and ensuring that ECF CHOICES is the payer of last resort. Always submit the primary payment on the claim submitted. Please confirm that this has been completed prior to submitting claims to DentaQuest to avoid delayed reimbursement.

In accordance with ECF CHOICES policy CON05-001, TennCare’s payment for a covered service, less any applicable Medicaid deductibles or copays is considered payment in full. Participating providers are required to accept TennCare’s payment as payment in full.

3.00 Utilization Management

3.01 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. The Tennessee Dental Director will review the enrollee’s treatment plan for medical necessity and make any changes as necessary. DentaQuest will review prior authorization treatment plans submitted to determine the medical necessity for dental treatment and the dentist must not divert from that treatment unless additional approval is given by the DentaQuest or except in a case of emergency. Diverting from a previously authorized service poses concerns with the
authorization process, billing and payment, and potentially, expenditure cap impact.

3.02 Community Practice Patterns

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 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.

Where community practice patterns are inconsistent with TennCare’s medical necessity criteria and the dental necessity guidelines presented in this Office Reference Manual, ECF CHOICES Rules, medical necessity rules and dental necessity guidelines will take precedence. Procedures that have been identified as inconsistent with these policies should not be included in any statistical analysis or evaluation of provider performance. For example, if a community of dentists practice prophylactic stainless steel crown use, which is excluded from coverage under ECF CHOICES because it does not comport with TennCare’s rules for medical necessity, these procedures will be excluded from provider averages and comparisons.

3.03 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.

3.04 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 for ECF CHOICES enrollees 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 for payments made for services that were not medically necessary.

3.05 Medical Necessity Guidelines

Medically Necessary is defined by statute in TCA § 71-5-144. These laws are implemented in TennCare/ECF CHOICES rules 1200-13-13-.01 and 1200-13-16 as well as the clinical criteria in this manual. The following are the basic medical necessity criteria.

To be medically necessary, a medical item or service must satisfy each of the following criteria:

1. It must be recommended by a licensed physician who is treating the Member or other licensed healthcare provider practicing within the scope of his or her license who is treating the Member;

2. It must be required in order to diagnose or treat a Member’s medical condition;

3. It must be safe and effective;

4. It must not be experimental or investigational; and

5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the Member’s medical condition.

The convenience of a Member, the Member's family, the Member’s caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.

4.00 Inpatient and Outpatient Hospital Services
4.01 Prior Authorization

Any proposal to render covered services that are medically necessary in an inpatient or outpatient surgical setting must be submitted to DentaQuest for prior authorization of dental treatment to be performed in the medical facility. The request must include:

1. Completed ECF CHOICES Inpatient and Outpatient Hospital Readiness Pre-admission Form - see Appendix A of this manual,

2. Copy of the patient’s dental record including health history, charting of the teeth and existing oral conditions,

3. Diagnostic radiographs or caries-detecting intraoral photographs*,

4. Copy of treatment plan. Note: A completed ADA claim form submitted for an authorization is considered to be the treatment plan,

5. Narrative describing medical necessity for hospital services.

* On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intraoral photographs to be made in the dental office setting. If this occurs, it must be noted in the patient record and on the ECF CHOICES Inpatient and Outpatient Hospital Readiness Pre-admission form (see Appendix A of this manual for required form). However, once the patient is sedated in a medical facility, appropriate diagnostic radiographs and/or intraoral photographs must be made to satisfy the authorization/medical necessity requirements. Dentists who “routinely” fail to submit radiographs or intraoral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion.

DentaQuest will review prior authorization treatment plans submitted to determine the medical necessity for dental treatment in a medical facility. The preauthorization of dental treatment will be processed by DentaQuest. DentaQuest will coordinate with the MCO as necessary. Please note that DentaQuest is not responsible for paying facility or related anesthesia charges associated with the provision of covered services that are medically necessary performed in an inpatient, outpatient or free-standing ambulatory surgical center. DentaQuest shall provide a prior authorization number to such Providers for inclusion on a
UB-92 or HCFA 1500, as applicable that shall be submitted directly to the Member’s MCO.

Non-emergency hospitalization is appropriate in the following situations:

1. Documentation of psychosomatic disorders that require special handling. Enrollees that requiring extensive operative procedures such as multiple restorations, abscess treatments, or oral surgical procedures may be eligible for hospitalization if prior authorization documentation indicates in-office treatment (conscious sedation/nitrous oxide) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension. Individuals with cognitive disabilities may have prior treatment history indicating that hospitalization is appropriate.

2. Hospitalized individuals who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.

3. Other medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures.

4. A medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment not medically acceptable.

5. A medical history of uncontrolled diabetes, in a situation where oral and maxillofacial surgical procedures are being performed.

Please note that a physician’s original written authorization is required if hospitalization is requested for an institutionalized individual.

4.02 Participating Hospitals and Surgery Centers

Upon approval, participating dentists are required to administer services at the Member’s MCO’s participating hospitals when services are not able to be rendered in the dental office. Participating dentists routinely bringing cases to medical facilities should obtain privileges at multiple facilities.

Participating Hospitals may change. Please contact plan for current listing.

AmeriGroup: www.myamerigroup.com
BlueCare: www.bluecare.bcbst.com
United Healthcare Community Plan: www.uhcrivervalley.com/TennCare
5.00 Claim Submission Procedures

DentaQuest strongly encourages all contracted Providers to submit claims electronically.

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 IB_5010 File.
- Paper ADA approved dental format.

5.01 Electronic Claim Submission Utilizing DentaQuest’s Internet Website

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

To submit claims via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State’ and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest’s Customer Service Department at 855-418-1623. 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 at 800.417.7140 or via e-mail at:

EDITeam@greatdentalplans.com or DL-ECFCHOICESTN@greatdentalplans.com

5.02 Electronic Attachments

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

**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.neafast.com](http://www.neafast.com) or call NEA at: 800.782.5150

5.03 **Electronic Claim Submission via Clearinghouse**

DentaQuest works directly with Change Healthcare (888.255.7293), Tesia (800.724.7240), EDI Health Group (800.576.6412), Secure EDI (877.466.9656) and Mercury Data Exchange (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.

5.04 **HIPAA Compliant 837D File**

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

5.05 **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](https://nppes.cms.hhs.gov/NPPES/Welcome.do) and provide this information to DentaQuest Dental in its entirety.
All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation. When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI’s. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

5.06 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms (2006 or 2012 only) 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 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 – ECF CHOICES Claims  
PO Box 2906  
Milwaukee, WI  53201-2906

5.07 Coordination of Benefits

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

5.08 Filing Limits

Participating Provider shall have no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file an initial claim with DentaQuest except in situations regarding coordination of benefits or subrogation in which case the Provider is pursuing payment from a third party or if a Member is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that DentaQuest receives notification from ECF CHOICES of the Member's eligibility.

In the event that a provider has a filed a claim within the required 120 day filing period, but the claim is denied as a result of administrative guidelines such as: missing documentation, Member eligibility status, missing claim details, the claim may still be considered for reimbursement. Upon receipt of the missing information or change in Member status, DentaQuest will reconsider the claim denial if the initial filing time line can be verified as occurring within the required 120 filing period and the additional information received is sufficient to meet payment guidelines. In this scenario, DentaQuest will honor the initial filing date and process the claim accordingly.

**Please note: DentaQuest’s system will not automatically override the filing limits, therefore, a provider must contact DentaQuest provider services to assist with the handling of the claim to ensure that it does not deny for untimely filing.
Participating Provider shall have no more than five (5) business days from
the date of a treatment plan to forward that information to DentaQuest
DL-ECFCHOICESTN@greatdentalplans.com except in situations regarding
coordination of benefits or subrogation in which case the Provider is
pursuing payment from a third party or if a Member is enrolled in the
plan with a retroactive eligibility date. DentaQuest will review the
treatment plan within three (3) business days.

5.09 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
at 855.418.1623 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.

5.10 Electronic Funds Transfer EFT (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 the Direct Deposit Program,
Providers must:

- Complete and sign the Direct Deposit Authorization 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 Authorization Form and voided check to
  DentaQuest:

  Via Fax - 262.241.4077 or

  Via Mail -
  DentaQuest – ECF CHOICES
  PO Box 2906
The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

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

Providers enrolled in the Direct Deposit Program are required to access their remittance statements on line 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.dentaquestgov.com
2. Once you have entered the website, click on the “Dentist” icon. From there choose your ‘State” and press go.
3. Log in using your password and ID
4. Once logged in, select “Claims/Pre-Authorizations” and then “Remittance Advice Search”.
5. The remittance will display on the screen.

5.11 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, and/or the Bureau of TennCare and ECF CHOICES harmless for the payment of non-covered Services except as provided in this paragraph.

Providers 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 and/or the Bureau of TennCare and ECF CHOICES will not pay for or be liable for said services; and
- Member will be financially liable for such services.
If you reach an agreement to bill a Member for a non-covered service, do not submit the claim to DentaQuest. Submission of such services will render the arrangement with the Member null and void.

6.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider agreements 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 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com.

7.00 Appeals and Grievances

DentaQuest adheres to State, Federal, and ECF CHOICES requirements related to processing inquiries and appeals.

Note:
- Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 855.418.1623.

7.01 Member Appeal Process

If a provider receives a notice from DentaQuest advising that provider’s prior authorization request has been denied, the ECF CHOICES member will have also received the NOAA that details the member’s appeal rights.

In the event that a dental service prior authorization request is denied by DentaQuest, the ECF CHOICES member has the right to appeal the denial to TennCare. With the member/member parent or guardian's oral consent, a provider may file a TennCare service appeal on the member's behalf. The NOAA instructs how to file such an appeal with TennCare either over the telephone or in writing.

Once a member appeal is filed, TennCare will conduct an appeal as required under Federal law. a. If the Appeal finding upholds the adverse benefit determination, the Member will have the option to request a State Fair Hearing as provided for under Federal law to review the Appeal finding. If the Hearing process results in a decision overturning DentaQuest's denial, DentaQuest will be instructed by TennCare to approve provision of the service.

PLEASE NOTE:
The TennCare member appeals process does not handle provider issues which have not resulted in an Adverse Benefit Determination affecting the ECF CHOICES member’s receipt of a benefit. For example, payment disputes between the provider and DentaQuest must NOT be filed as TennCare
member appeals. If resolution of the issue under dispute does not affect whether the ECF CHOICES member will receive a service (or reimbursement of a service), then the appeal should be filed as a Provider Appeal. See section 7.02 for an explanation of the Provider Appeal process.

Rights and Responsibilities Regarding Member Appeals:

ECF CHOICES members have the right to appeal any Adverse Benefit Determination taken by DentaQuest. An Adverse Benefit Determination is anything that denies, reduces, terminates, delays, or suspends an ECF CHOICES covered service, as well as any acts or omission which impair the quality, timeliness, or availability of ECF CHOICES covered services. Appeals involving denials of authorizations for care for ECF CHOICES members may be lodged by the member or by anyone (including the treating provider) acting on the member’s behalf. Dental providers play an important role in the appeal process for ECF CHOICES members. Among providers’ responsibilities is the obligation to supply at no cost to TennCare or DentaQuest, those medical and dental records necessary to substantiate the member’s appeal.

7.02 Provider Appeal Process (Post-Service Appeals)

Providers have multiple options to appeal a decision post-service.

DentaQuest Provider Appeal

Participating Providers that disagree with claims processing determinations made by DentaQuest may submit a written notice of disagreement to DentaQuest that specifies the nature of the issue. The Provider Appeal form, located in Appendix A-9, can be used for this purpose. The appeal must be sent within 60 days from the date of the original determination.

All provider appeals received timely by DentaQuest will be reviewed by the Complaints and Grievances department for review and reconsideration, which includes review by a clinical professional. The department will respond in writing with its decision to the Provider.

Tennessee Department of Commerce and Insurance Complaint Process

The TDCI Provider Complaint process is a courtesy provided to dental providers who have a complaint against DentaQuest. This process is free.
Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from DentaQuest, miscommunication or confusion around DentaQuest policy and procedures, etc.

When a provider complaint is received, the Bureau will forward the complaint to DentaQuest for investigation. DentaQuest is required to respond in writing to both the provider and the TennCare Oversight Division by a set deadline to avoid assessment of liquidated damages or other appropriate sanction.

If the provider is not satisfied with DentaQuest's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an Independent Reviewer for resolution or pursuing other available legal or contractual remedies.

Instructions and current copies of the forms can be obtained on the state’s Web site at http://tn.gov/tnoversight/PCIR.shtml.

**TDCI TennCare Provider Independent Review of Disputed Claims**

In addition to the above process, Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the ECF CHOICES Provider Independent Review of Disputed Claims process.

The Independent Review process was established by statute (Tennessee Code Annotated § 56-32-126(b)(2)) to resolve claims disputes when a provider believes a TennCare Managed Care Company (MCC) such as DentaQuest has partially or totally denied claims incorrectly. A failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within sixty (60) days of DentaQuest's receipt of the claim is considered a claims denial.

There is a $450 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCC is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCC, the provider is responsible for paying the fee.

The independent review process is only one option a provider has to resolve claims payment disputes with a TennCare MCC. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.
7.03 Member Grievances

DentaQuest’s process for handling Member Grievances against Providers and/or DentaQuest is as follows:

1. The Member Grievance process shall only be for Grievances as defined in Section 16.00. DentaQuest and the Providers shall ensure that all Member Appeals, as defined in sections 7.00 through 7.02, are addressed through the Appeals process, rather than through the Grievance process.

2. DentaQuest and the Provider shall allow a Member to file a Grievance either orally or in writing at any time.

3. Provider shall forward a copy of any written Member Grievance the Provider receives to DentaQuest within one (1) business day of receipt from Member. Provider shall forward to DentaQuest a full and complete written version of any Grievance received orally from a Member within one (1) business day of receipt from Member. All such transmissions of Member Grievance to DentaQuest shall be made electronically, via secure email or facsimile transmission.

3. Within five (5) business days of receipt of the Grievance, DentaQuest shall provide written notice to the Member and the Provider (if the Grievance was against the Provider) that the Grievance has been received and the expected date of resolution. However, if DentaQuest resolves the Grievance and verbally informs the Member, and Provider if appropriate, of the resolution within five (5) business days of receipt of the Grievance, DentaQuest shall not be required to provide written acknowledgement of the Complaint to the Member, and Provider if appropriate.

4. DentaQuest shall resolve and notify the Member and the Provider (if the Grievance was against the Provider) in writing of the resolution of each Grievance as expeditiously as possible but no later than thirty (30) days from the date the Complaint is received by DentaQuest. The notice shall include the resolution and the basis for the resolution. However, if DentaQuest resolved the Grievance and verbally informed the Member and Provider, if appropriate, of the resolution within five (5) business days of receipt of the Grievance, DentaQuest shall not be required to provide written notice of resolution to either the Member or the Provider (if the Grievance was against the Provider).

5. DentaQuest and Providers shall assist Members with the Grievance process.
6. DentaQuest shall resolve each Member Grievance with assistance from the affected Provider, as needed, and Provider shall comply with DentaQuest’s request for assistance. The resolution process includes various methods of determining the cause of, and the appropriate resolution of, a Grievance, including, but not limited to, use of a corrective action plan (CAP). A CAP is a plan to correct Provider’s noncompliance with the Provider Agreement (including noncompliance resulting in Member Grievance) that the Provider prepares on his/her own initiative, or at DentaQuest’s request, to submit to DentaQuest for review and approval. Provider shall respond timely to the CAP request and take all CAP actions that have been approved by DentaQuest. Failure to comply with a request to provide a CAP or the terms and conditions of an approved CAP may result in actions against the Provider, including termination of the affected Provider’s Provider Agreement by DentaQuest. The various components of a CAP are as follows:

a. **Notice of Deficiency**: If DentaQuest determines that the Provider is not in compliance with a requirement of the Provider Agreement (including, but not limited to, issues relating to a Member’s Grievance) DentaQuest will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Provider intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to DentaQuest and may also contain recommendations or requirements the Provider must include or address in the CAP.

b. **Proposed CAP**: Upon receipt of a Notice of Deficiency, the Provider shall prepare a proposed CAP and submit it to DentaQuest for approval within the time frame specified by DentaQuest. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.

c. **Approved CAP Implementation**: DentaQuest will review the proposed CAP and work with the Provider to revise it as needed. Once approved, the Provider shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the CAP, to DentaQuest’s satisfaction.

d. **Notice of Completed CAP**: Upon satisfactory completion of the implemented CAP, DentaQuest shall provide written notice to the Provider. Until written approval is received by the Provider, the approved CAP will be deemed to not have been satisfactorily completed.
7. DentaQuest shall track and trend all Member Grievances, timeframes and resolutions and ensure remediation of individual and/or systemic issues.

8. Upon request, DentaQuest shall submit reports regarding Member Grievances to TennCare.

9. Member Grievances pertaining to discrimination shall be handled in accordance with the separate Nondiscrimination process outlined in this manual in Section 1.01.

8.00 Fraud and Abuse

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

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

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

**Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid program.

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

**ECF CHOICES TennCare Fraud Hotline:** 800.433.3982

You can find more information about reporting fraud and abuse @ [http://www.tn.gov/tenncare/fraud.shtml](http://www.tn.gov/tenncare/fraud.shtml)

**False Claims Act Information**

**Purpose**
To provide information about the False Claims Act (the “FCA”) and related legal requirements as required by the Deficit Reduction Act of 2005.

Policy

It is the policy of DentaQuest to provide service in a manner that complies with applicable federal and state laws and that meets the high standards of professional ethics. To further this policy DentaQuest provides the following information about the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

1. Federal False Claims Laws

The False Claims Act FCA, 31 U.S.C. §§ 3729-2733, imposes liability on any person or entity who knowingly files an unjustified or false claim for payment to Medicare, Medicaid or other federally funded health program.

“Knowingly” means that a person has actual knowledge that the information on the claim is false; acted in deliberate ignorance of whether the claim is true or false; or acted in reckless disregard of whether the claim is true or false.

A person or entity found liable under the FCA is, generally, subject to three times the dollar amount that the government is defrauded and penalties of $5,500 to $11,000 for each false claim. If there is a recovery in the case brought under the FCA, the person bringing the suit may receive a percentage of the recovery. For the party found responsible for the false claim, the government may seek to exclude it from future participation in Federal healthcare programs or impose additional obligations against it.

2. Anti-Retaliation Protection

DentaQuest encourages personnel to report any concerns relating to potential fraud and abuse, including false claims.

The FCA states that no person will be subject to retaliatory action as a result of their reporting of credible misconduct.

Pursuant to DentaQuest’s compliance with the FCA and other applicable DentaQuest policies and procedures, no team Member will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment.
by DentaQuest solely because of actions taken to report potential fraud and abuse or other lawful acts by the team Member in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

3. Anti-Fraud Hotline

The Anti-Fraud hotline can be accessed by calling 800.433.3982. DentaQuest investigates all incoming calls to determine if the allegations are warranted. Based upon the information received from callers, the proper course of action is determined.

4. Monthly Screening requirement

For the purpose of the Monthly Screening Requirements, the following definitions shall apply:


“Ineligible Persons” means any individual or entity who: (a) is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their monthly obligation to screen all employees and contractors (the “Monthly Screening Process”) against the Exclusion Lists to determine whether any of them have been determined to be ineligible Persons, and therefore, excluded from participation as a Medicaid Provider. Providers are also required to have employees and contractors disclose whether they are Ineligible Persons prior to providing any services on behalf of the Provider. The Monthly Screening Process is a Centers for Medicare & Medicaid Services (CMS) requirement and a condition of their enrollment as a DentaQuest Medicaid Provider and is also a continuing obligation during their term as such.
Medicaid Providers must immediately report any exclusion information discovered to DentaQuest.

If Provider determines that an employee or contractor is or has become an Ineligible Person, Provider will take the appropriate action to remove such employee or contractor from responsibility for, or involvement with Provider’s operations related to Federal health care programs. In such event, the Provider shall take all appropriate actions to ensure that the responsibilities of such employee or contractor have not and will not adversely affect the quality of care rendered to any DentaQuest Member of any Federal health care program.

5. Credible Allegation of Fraud

Pursuant to Federal law at 42 CFR 455.23 the Bureau of TennCare may direct DentaQuest to suspend payments to a Provider where the TennCare Bureau has made a determination that there is a credible allegation of fraud against the provider that is currently under investigation. In the event of such a suspension the Provider must work directly with the Bureau of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Bureau of TennCare.

6. Other Program Integrity Actions

DentaQuest is required in its contract to report suspected cases of Provider fraud and abuse to TennCare. In addition, TennCare conducts its own independent Program Integrity functions. In the event that a provider is contacted by the Bureau of TennCare concerning a Program Integrity matter, the Provider must work directly with the Bureau of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Bureau of TennCare.

9.00 Quality Monitoring Program (QMP)

DentaQuest maintains a comprehensive Quality Management Program to objectively monitor and systematically evaluate the care and service provided to Members. The program is modeled after National Committee for Quality Assurance (NCQA) standards; the NCQA standards are adhered to as the standards apply to dental managed care. In addition, DentaQuest’s Quality Management Program is in compliance with ECF CHOICES guidelines. The scope and content of the program reflects the demographic and epidemiological needs of the population served.
DentaQuest uses the results of QMP activities to improve the quality of dental health in association with appropriate input from providers and Members. The evaluation of the QMP addresses Quality Monitoring studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. This quality survey will be released annually to the provider network. Each provider will get specific notification.

The Quality Management Program includes:

- Provider Credentialing and Recredentialing
- Member Satisfaction Surveys
- Provider Satisfaction Surveys
- Random Chart Audits
- Member Appeal Monitoring and Trending
- Peer Review Process
- Utilization Management and Practice Patterns
- Site Reviews and Dental Record Reviews
- Patient Safety
- Service Initiatives
- Compliance Monitoring
- Quarterly Quality Indicator Tracking (i.e. Member appeal rate, appointment waiting time, access to care, etc.)

The QMP includes both improvement and monitoring aspects, and requires the ongoing process of:

-- Responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

-- Assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.

The QMP also includes written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not furnished.
DentaQuest maintains a comprehensive committee structure with oversight from the governing body to facilitate quality monitoring program activities.

**Quality Monitoring Program Committee:**
The purpose of the Quality Management Committee is to maintain quality as a cornerstone of the DentaQuest culture and to be an instrument of change through demonstrable improvement in care and service. The QMP Committee is accountable to DentaQuest’s Governing Body, which approves the overall QMP, Work Plan, and Annual Evaluation. The Committee analyzes and evaluates the results of QMP activities, recommends policy decisions, ensures that providers are involved in the QMP, institutes needed action, and ensures that appropriate follow-up occurs.

**Provider Peer Review Committee**
DentaQuest maintains a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. A participating ECF CHOICES provider is a member of this committee. This Committee meets regularly to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers.

A copy of DentaQuest’s QMP is available upon request by contacting DentaQuest’s Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com.

**10.00 Credentialing**

DentaQuest has the sole right to determine which dentists (DDS or DMD) from the pool of dentists which have a valid Medicaid ID number as issued by TennCare they shall accept and allow to continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, monitoring, 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.

DentaQuest’s credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry and is in full compliance with TennCare guidelines.

Nothing in this Credentialing Plan limits DentaQuest’s discretion to accept or 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.
DentaQuest must credential each provider location and DentaQuest is not required to credential all of a provider’s locations.

DentaQuest has the final decision-making power regarding network participation.

**Appeal of Credentialing Committee Recommendation (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)**

**Recredentialing (Policy 300.016A)**

Network Providers are re-credentialed at least every 36 months pursuant to TennCare guidelines.

Note: The aforementioned policies are available upon request by contacting DentaQuest’s Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com

**11.00 The Patient Record**

Participating Providers are required to maintain proper patient records.

**11.01 Accessibility and availability of Dental Records**

**Corrections/Alteration Protocols:**

There are times when it is necessary to make a correction to a patient record; this need to make corrections should be an exception not a pattern. Any corrections, late entries, entries made out of sequence and addenda made in a patient record should be clearly marked as such in the record. A single line should be drawn through any erroneous chart entry and the word “error” should be noted; the correct treatment should be noted with the correct treatment referenced and these corrections should be signed and dated. In incidents where correction or alterations would need to be completed on a later date, the addenda and/or corrected treatment information should be entered “chronologically and refer to the date of visit in question.
According to the American Dental Association Council on Dental Practice Division of Legal Affair publication” Dental Records” published in 2010:

• Cross out the wrong entry with a thin line and make the appropriate change;
• Date and initial each change or addition;
• Never obliterate an entry with markers or white-out, as you and/or a third party must be able to read the wrong entry;
• Do not leave blank lines between entries;
• Do not insert words or phrases in an entry;
• If a correction needs to be made at a later date, enter the correction chronologically but reference the date in question that you are correcting.

According to CMS Program Integrity:

Any record that contains delayed entries, amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such; and
2. Clearly indicate the date and author of any amendment, correction, or delayed entry, and;
3. Not delete but instead clearly identify all original content.
4. Corrections, amendments or delayed entries to paper records must be clearly signed and dated upon entry in the record.

1 American Dental Association Dental Records – 2010
2 CMS Manual System Pub 100-08

11.02 Recordkeeping

Dental records may be on paper or electronic media. DentaQuest requires that dental records be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

Dental Record Standards – DentaQuest sets standards for dental records. These standards shall, at a minimum, include requirements for:

a. Member Identification Information - Each page in the record contains the patient’s name or enrollee ID number.

b. Personal/biographical Data - Personal/biographical data includes: age; gender; address; employer; home and work telephone numbers; and marital status.
c. Entries - All entries are dated on the day of service. Entries shall detail services provided and be signed by the rendering provider.

d. Provider Identification - All entries are identified as to author.

e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.

f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location.

g. Past Medical History - (for Members seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For orthodontics requested secondary to speech pathology, obtain speech/language records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency.

h. Diagnostic information.

i. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

j. Tobacco Use - (For Members 12 years and over and seen three or more times) Notation concerning tobacco use is present. Abbreviations and symbols may be appropriate.

k. Referrals and Results Thereof.

m. Emergency Care.

n. Compliance with Tennessee Board of Dentistry Rule 0460-02-.12

o. Substance abuse and mental health treatment information (behavioral health records) – Records shall be kept separate and apart from the medical record in compliance with federal law.

**Patient Visit Data** – Documentation of individual encounters must provide adequate evidence of, at a minimum:
a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.

b. Plan of Treatment.

c. Diagnostic Tests.

d. Therapies and other Prescribed Regimens.

e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

f. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment.

g. All Other Aspects of Patient Care, Including Ancillary Services.

h. Documentation of sedation (please see section 15.09).

Record Review Process

- DentaQuest has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.

- The record assessment system addresses documentation of the items listed in the Patient Visit Data section above.

12.00 Patient Recall System Requirements

A. Recall System Requirement

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

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

- “We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy.”

- “Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help.”

Dental offices indicate that ECF CHOICES patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the “no show” rate. Please note that Members cannot be charged for missed appointments.

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

- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

- Have the Member contact the provider’s office prior to the appointment to confirm the time and place of the appointment.

B. Office Compliance Verification Procedures

DentaQuest will measure compliance with the requirement to maintain a patient recall system. Participating Providers are expected to meet minimum standards regarding appointment availability:

- Emergency care must be provided within 24 hours and is defined as an unscheduled episode that requires a service to patients who present for immediate attention. The condition, if untreated, could place the patient’s health in jeopardy or cause serious consequences.

- Urgent care, those involving pain, infection, swelling and/or traumatic injury, must be available within 48 hours.
• DentaQuest ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member’s treating dentist, other dental professional, primary care provider or triage nurse who is trained in dental care and oral healthcare.

• Initial and recall routine treatment must be scheduled within 21 days of initial contact with the dentist’s office.

• Follow-up appointments must be scheduled within 21 days of the present treatment date. DentaQuest requires that a patient be seen within 45 minutes of arriving at the office, or be given the opportunity to reschedule.

• Participating Providers unable to meet these guidelines must refer the Member back to DentaQuest. DentaQuest will then be responsible for arranging needed care in the appropriate time frames. The number for Members to call for assistance is:

  855.418.1622 for ECF CHOICES Members

13.00 Radiology Requirements

DentaQuest recommends that you submit your attachments and x-rays through an electronic attachment service.

When mailing x-rays for authorization with the claim, **ALWAYS SUBMIT A DIAGNOSTIC QUALITY DUPLICATE OF THE X-RAY.** X-rays **WILL NOT** be returned unless a stamped, self-addressed envelope is attached to the request.
14.00 Clinical Criteria

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. All covered dental services must also be Medically Necessary as defined by TennCare Rules. The clinical criteria presented in Section 14.01 through 14.11 are the criteria that DentaQuest dental benefit reviewers will use for making medical necessity determinations for those specific procedures. In addition, please review the general benefit limitations for certain dental procedures presented in Exhibit A. Exceptions to general benefit limitations may be made on an individual enrollee basis if medically necessary.

For all procedures, every provider in the DentaQuest program is subject to random chart/treatment audits. These audits may occur in the Provider’s office as well as in the office of DentaQuest. Based on the findings of any audit, the Provider will be notified of the results of the audit. In the event that audit findings require examination by the DentaQuest Tennessee Peer Review Committee, any requested records must be made available upon request to DentaQuest.

Whether a procedure requires prior authorization or not, all procedures require acceptable documentation standards be met. Documentation for all procedures rendered must justify the need for the procedure performed due to medical necessity.

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Postoperative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Failure to provide the required documentation, 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. Additionally, the provider may be referred to the Bureau of TennCare for possible actions impacting the provider’s ability to participate in ECF CHOICES, TennCare, CoverKids, or other state programs.

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

14.01 Criteria for Dental Extractions

Documentation needed for authorization procedure:

Diagnostic radiographs (strongly encourage digital) that are labeled Right (R) and Left (L) and the date the radiographs were taken, not submitted, showing clearly the adjacent and opposing teeth submitted for authorization (whether prior or post service) review; bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when prior-authorization (authorization prior to service) is not possible, will still require that appropriate radiographs be submitted with the claim for review for payment. This is considered retro-authorization.

Authorization for extraction of un-erupted third molars
Benefit review decisions for the authorization of un-erupted third molar tooth extractions will be based upon medical necessity and upon appropriate CDT nomenclature.

In other words, providers must use the most current and appropriate ADA Code(s) on Dental Procedures and Nomenclature (CDT) when submitting either a prior-authorization or retro-authorization for un-erupted third molar extractions.

- The prophylactic removal of disease-free un-erupted third molars is not considered medically necessary and, therefore, will not be authorized.
- Impaction alone, absent pathology does not meet medical necessity criteria and therefore will not be authorized.
- For an extraction to be considered medically necessary an un-erupted third molar must show pathology, or
- An un-erupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations and substantial (> 50%) root formation.
• Discomfort from natural tooth eruption not caused by pathology or an aberrant tooth position will not qualify an un-erupted third molar extraction for authorization.

• When at least a single third molar meets the criteria above, the DBM may, at its complete clinical discretion and on a case-by-case basis, approve the extraction of additional un-erupted third molar teeth to avoid risk from multiple exposures of the member to anesthesia.

• Routine incision and drainage is not considered a separate benefit if the extraction serves in this function.

• Alveoloplasty in conjunction with extractions require:
  o A minimum of 4 teeth removed in a quadrant to qualify for the code
  o Narrative supporting necessity for prosthetic placement
  o Treatment notes must indicate that an Alveoloplasty is a separate surgical procedure from tooth removal.

• Alveoloplasty not in conjunction with extractions require:
  o A minimum of 4 tooth spaces in a quadrant to qualify for the code
  o Narrative supporting necessity for prosthetic placement
  o Not allowed with extractions in same quadrant on same date of service.

• Tooth re-implantation:
  o Must include a narrative indicating accident or trauma
  o Must include a periapical radiograph
  o Can only be reviewed retrospectively.

14.02 Criteria for Crowns

Documentation needed for authorization of procedure:

• Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth should be submitted for prior authorization or with the claim once service has been rendered; bitewings, periapicals or panorex.
• Appropriate diagnostic radiographs showing the completed restoration must be in the patient’s record.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

Criteria:

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

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

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

• Permanent anterior teeth should have 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.
A request for a core build up or a cast core must meet the following criteria:
  - Presence of greater than 50% bone support
  - Absence of sub-osseous decay and/or furcation involvement
  - Absence of tooth structure to support crown
  - Clinically acceptable root canal fill (post and core)

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.

Crowns on permanent teeth are expected to last a minimum of 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.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent destruction due to caries or trauma.

**14.03 Criteria for Endodontics**

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) 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 showing properly condensed/obturated canal(s), for review for payment.

**Note:** Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.
Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

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

Authorization for Root canal therapy must meet the following criteria:

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

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

Authorizations for root canal therapy, root canal re-treatment, apicoectomies and apexification 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 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- 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 obturation 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.

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

- 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 arches or is 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.

14.04 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU)

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In emergencies).

Providers must submit the following documents or review by DentaQuest for authorization of OR cases:

- Provision of dental in treatment in a hospital or SPU requires informed consent.
• Provision of dental treatment in OR or SPU requires prior authorization from DentaQuest unless such dental treatment constitutes an emergency. An emergency is defined as a situation where waiting for treatment could seriously jeopardize the enrollee’s life, physical health, or mental health or their ability to attain, regain, or maintain full function. Providers requesting PA for dental treatment in OR or SPU must submit the following documentation with their PA request in order for DentaQuest to determine whether the PA request meets medical necessity and clinical criteria:

• Completed ECF CHOICES Inpatient and Outpatient Hospital Readiness Preadmission Form. (see Appendix A-8 of this manual for required form) This form must evidence that the requesting dental provider attempted to treat the patient in-office and, where appropriate, referred the patient to a specialist.

• Copy of the patient’s dental record including health history, charting of the teeth and existing oral conditions*.

• Diagnostic radiographs or caries-detecting intra-oral photographs.

• Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.

• Narrative describing medical necessity for OR.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

† On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intra-oral photographs to be made. If this occurs, it must be noted in the patient record and narrative describing medical necessity. Dentists who “routinely” fail to submit radiographs or intra-oral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.
*Dental Records are regulated by the Rules of the Tennessee Board of Dentistry 0460-2-.11 Regulated Areas of Practice (5a and b).

The provider is responsible for choosing facilities/providers from Member’s MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient’s primary care provider. DentaQuest would not recommend that providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.

Criteria:

Sedation services are only provided based upon the needs of the Member and not the convenience of the provider. Instances where sedation services may be appropriate include dental services for ECF CHOICES members: a. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant; and b. Have dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity; and c. For which dental treatment under local anesthesia, and other alternative adjunctive techniques and modalities have not been successful in producing a successful result and which, under general anesthesia, can be expected to produce a superior result.

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

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

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

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other
medical condition that renders in-office treatment medically appropriate.

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

• Individuals with cognitive disabilities requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.05 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

• Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

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 majority of teeth 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.

• In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally, or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. 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 (lodge, gag reflex, potential for swallowing the prosthesis, severe disability).

• 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.

Benefit 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.

• 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.

After that time has elapsed:

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

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

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

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

• Replacement of lost, stolen, or broken dentures less than 5 years of age 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.

14.06 Criteria for the Excision of Bone Tissue

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

CDT codes D7471, D7472, and D7473 are related to the removal of exostoses. These codes are 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 intra-oral photographs and/or study models - which clearly identify the exostosis must be submitted for authorization review; bitewings, periapicals or panorex.

• Copy of detailed treatment plan– including prosthetic plan.

• Narrative of medical necessity, if appropriate.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

14.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

14.08 **Criteria for General Anesthesia and IV Sedation**

Participating Providers who perform in office sedation must comply with the rules and regulations established by the Tennessee Board of Dentistry as they apply to sedation. Failure of Providers to provide compliant documentation of sedation in the patient record will result in corrective action and recoupment of monies paid for non-compliant sedation.

Sedation services are only provided based upon the needs of the Member and not the convenience of the provider. Instances where sedation services may be appropriate include dental services for ECF CHOICES members: a. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant; and b. Have dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity; and c. For which dental treatment under local anesthesia, and other alternative adjunctive techniques and modalities have not been successful in producing a successful result and which, under general anesthesia, can be expected to produce a superior result.
Documentation needed for authorization of procedure:

- Diagnostic radiographs or intra-oral photographs
- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when prior authorization is not possible, will still require submission of appropriate documentation with the claim for review for payment.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Criteria:

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by ECF CHOICES) if the following criteria are met:

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 or intellectual disability) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

14.09 Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

- Diagnostic radiographs – periapicals or bitewings preferred.
- Copy of detailed treatment plan
• Narrative of medical necessity addressing pre and postoperative prognosis for surgical cases
• Intra-oral photographs clearly identifying the condition in cases of gingival hyperplasia

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

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:

- Four (4) of Eight (8) 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 significant loss of bone support

Periodontal gingival flap surgical procedures must meet the following criteria:
- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites after scaling and root planing
- Moderate to severe bone loss.

Gingivectomy procedures must meet the following criteria:
- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites of 5mm or greater after periodontal scaling and root planing
- Narrative of hyperplasia or hypertrophy associated with drug therapy, orthodontic treatment, hormonal disturbances, or congenital defects.
- Or, evidence of juvenile periodontitis.

**14.10 Criteria for Occlusal Guards**

An occlusal guard (9940) is a removable appliance designed to minimize the effect of bruxism and other occlusal factors. To determine medical necessity the following criteria must be met:

- Occlusal guards require prior authorization.
- A narrative must be included on or with the claim defining why the occlusal guard is medically necessary. Occlusal guards for the purpose of tooth whitening trays, TMD (temporomandibular disorder) treatment or athletic mouth guards are not considered medically necessary criteria.
The fee for the occlusal guard includes six months of follow up care, including adjustments.

14.11 Criteria for Use of Silver Diamine Fluoride - D1354

DentaQuest, as a market leader in improving oral health, strongly supports the use of appropriate medically necessary diagnostic and preventive services. Consistent with that fundamental strategy, ADA CDT Code D1354 (Interim caries arresting medicament application) is now a covered service. The medicament MUST be a product approved by FDA for use as a caries arresting medicament, and use must be consistent with the narrative in the descriptor of this code.

DentaQuest and TennCare™ advocate that the clinical indication for the use of Silver Diamine Fluoride is the management and arresting of significant areas and frequency or numbers of carious lesions. Administration of this benefit will be limited to four applications during enrollee’s total period of eligibility, and there is a four week period after application that restorative treatment is not a covered service. This will assure the Silver Diamine Fluoride treatment and effect on the carious tooth structure has been able to approach desired completion. ADA CDT Code 1354 will not be covered on the SAME DAY as other fluoride applications.

After a four week interim period for completion of reaction, restorative treatment for carious teeth, (based on medical necessity) will then be covered service(s).

- Indications for SDF
  - SDF has been recommended for patients of any age, with:
    - extreme caries risk, behavioral or medical management challenges;
    - more carious lesions than are treatable in one operative visit;
    - difficult to treat lesions;
    - or, without access to comprehensive care.
15.00 General Definitions

The following definitions apply to this Office Reference Manual:

**Adverse Benefit Determination** – Adverse action affecting ECF CHOICES services or benefits as defined in 42cfr 438.400 shall mean, but it is not limited to, a delay, denial, reduction, suspension or termination of ECF CHOICES benefits, as well as any other act or omission of the ECF CHOICES Program which impairs the quality, timeliness, or availability of such benefits. See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

**Agreement** – The Provider Agreement between DentaQuest and Provider, including all attachments thereto.

**Appeal Process** – The process whereby an Enrollee exercises their right to contest verbally or in writing any adverse action taken by DentaQuest to deny, reduce, terminate, delay or suspend a Covered Service as well as any other acts or omissions of DentaQuest which impair the quality, timeliness, or availability of such benefits. The appeal process shall be governed by Federal law at 42CFR 438.100 et seq. ECF CHOICES rules, regulations and any and all applicable court orders and consent decrees. See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

**Benefits** – Shall mean the health care package of services developed by the Bureau of ECF CHOICES and which define the covered services available to ECF CHOICES enrollees. The Agreement focuses on Dental benefits although Benefits provided by the Enrollee’s MCO are sometimes mentioned. See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

**Bureau of TennCare** – Shall mean the Tennessee Department of Finance and Administration, Division of Health Care Finance and Administration, Bureau of TennCare responsible for administering the ECF CHOICES Program.

**CAQH** – Shall mean “The Council for Affordable Quality Healthcare,” a nonprofit alliance of health plans and trade associations, working to simplify the first steps of the provider credentialing and application data collection process.

**Clean Claim** – A claim received by DentaQuest for adjudication that requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by TennCare.

**Contract or TennCare Dental Benefits Manager Contract** – Shall mean the contract between TennCare and DentaQuest, identified as Edison Contract ID #36736, wherein DentaQuest contracted to be responsible for the financial,
clinical and managerial aspects of the TennCare dental benefits management (DBM) program.

**Covered Service** – Shall mean dental services, benefit services and benefits that are Medically Necessary, including ECF CHOICES services, and that satisfy all the criteria set forth in the ECF CHOICES Program rules, policies, the Agreement, and in this Provider Office Reference Manual.  
*See also ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01*

**Dental Benefits Manger (DBM)** – Dental Benefits Manager shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the ECF CHOICES Program to the extent such services are covered by TennCare. *See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01*

**Dental Home** – A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible and coordinated way.

**DentaQuest** - Shall refer to DentaQuest USA Insurance CO., LLC.

**DentaQuest Service Area** - Shall be defined as the State of Tennessee.

**Disallowed** – Procedures that are not paid benefits by ECF CHOICES or collectable from the ECF CHOICES Member.

**Emergency Medical Condition** – Emergency Medical Condition, including emergency mental health and substance abuse emergency treatment services, shall mean the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:
- Placing the person’s (or with respect to a pregnant woman, her unborn enrollee’s) health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For Medicaid enrollees only, copayments are not required for emergency services.  
*See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01*
Emergency Services – Covered inpatient and outpatient Emergency Medical Condition services that are furnished by a Provider who is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee – Enrollee shall mean an individual eligible for and enrolled in the ECF CHOICES Program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act.

Grievance – as defined in 42CFR438.100 is a Member’s right to contest an action taken by the Contractor or service provider that does not meet the definition of an Adverse Benefit Determination.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Mandates the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of individually identifiable health care information.

Health Information Technology for Economic and Clinical Health (HITECH) Act – Enacted to improve health care quality, safety and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information; to adopt an initial set of standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology; and to establish the capabilities and related standards that certified electronic health record technology (Certified HER Technology) shall need to include in order to, at a minimum, support the achievement of the proposed meaningful use by eligible professionals and eligible hospitals.

Managed Care Organization (MCO) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long term care services in the ECF CHOICES Program.

See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

Medically Necessary is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71-5-144, applies to ECF CHOICES enrollees. Implementation of the term “medically necessary” is provided for in the ECF CHOICES rules, consistent with the statutory provisions, which control in case of ambiguity. No
enrollee shall be entitled to receive and ECF CHIOCES shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.  

See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

**Medical Necessity Determination** – A decision made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of DentaQuest or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of Medical Necessity contained in Tennessee Code Annotated, Section 71-5-144 and these rules as defined herein. Items or services that are not determined medically necessary shall not be paid for by TennCare. See ECF CHOICES Rule 1200-13-13-.01, ECF CHOICES Rule 1200-13-14-.01 and ECF CHOICES Rule 1200-13-16(32)

**Medical Necessity Guidelines/Clinical Criteria** – Evidence-based guidelines approved by the Chief Medical Officer of the Bureau of TennCare for the purpose of guiding Medical Necessity determinations

**Member** - Shall mean an ECF CHOICES Medicaid eligible individual who is enrolled in a managed care organization.  

See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01

**Member Grievance** - Shall mean a Member’s right to contest an action taken by DentaQuest or the Provider that does not meet the definition of Adverse Benefit Determination.

**National Provider Identifier (NPI)** – The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for Covered Health Care Providers. Covered Health Care Providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI must be used in lieu of Legacy Provider identifiers in the HIPAA standards transactions.

**Non-covered Benefit/Services** – Items and services that are not within the scope of defined benefits for which a beneficiary is eligible under TennCare, including cost-effective alternative services and medical items and services that are in excess of any applicable limits on such items or services that might otherwise be covered. With the exception of cost effective alternative services, non-covered services under TennCare, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise
would qualify as “medically necessary”, regardless of the medical circumstances involved.

**Non-participating Provider** – Shall mean a DentaQuest dental provider who is not contracted as a DentaQuest Network Provider under the ECF CHOICES Program. *See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01*

**Provider or Participating Provider** - Shall mean an ECF CHOICES provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Dental Benefits Manager.

**Protected Health Information (PHI)** – Individually identifiable health information held or maintained by a covered entity or its business associates that is transmitted or maintained in any form or medium. This includes identifiable demographic and other information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

**Provider/DentaQuest Office Reference Manual (ORM)** – The manual provided that clearly defines ECF CHOICES Program covered services, limitations, exclusions and utilization management procedures, including, but not limited to, prior approval requirements and special documentation requirements (hospital readiness form, orthodontic readiness form, documentation of nutritional problems [general pediatric records including growth data], speech/hearing evaluations [may include school records]) for treatment of enrollees. The terms of the Provider Office Reference Manual are incorporated by reference into the DentaQuest Provider agreement. In the event of a discrepancy between the ORM and the ECF CHOICES Rules, the ECF CHOICES Rules shall apply.

**Specialty Services** – Includes Endodontic, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, and Prosthodontics.

**State** – State of Tennessee

**TennCare**– The program administrated by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee. *See ECF CHOICES Rule 1200-13-13-.01 and ECF CHOICES Rule 1200-13-14-.01*
Unsecured PHI – Protected health information that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the Department of Health and Human Services (DHHS).

16.00 Confidentiality and Safeguards

Provider acknowledges it is a covered entity under the HIPAA Rules and agrees to comply with all applicable HIPAA and HITECH (hereinafter “HIPAA/HITECH”) Rules. In accordance with HIPAA/HITECH, Provider shall comply with requirements of HIPAA/HITECH including, but not limited to, the Transactions and Code Sets, Security, Breach Notification, and Privacy Rules.

A. Transactions and Code Sets: Provider shall comply with the requirements of 45 C.F.R. Part 162, the HIPAA Transactions Rule. Compliance includes conducting electronic transactions using all applicable data content and data conditions of adopted standards and, when required, using the applicable formats for adopted standards. Providers must require any entity that conducts such transactions on its behalf to comply with all applicable requirements of 45 C.F.R. Part 162 and to require any Subcontractor to comply with all applicable requirements of 45 C.F.R. Part 162.

B. Security: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart C, the HIPAA Security Rule. Under the Security Rule, health care providers (and other covered entities) must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information and implement safeguards sufficient to reduce the identified risks and vulnerabilities to a reasonable and appropriate level.

C. Breach Notification: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart D, and the HIPAA Breach Notification Rule. When required by the Breach Notification Rule, Provider shall notify applicable parties of a “breach” of unencrypted protected health information. In addition, Providers shall also notify DentaQuest immediately upon becoming aware of any provisional or actual breach as it relates solely to ECF CHOICES members.

D. Privacy: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart E, and the HIPAA Privacy Rule. Among other things, the Privacy Rule requires a Provider to:
• Implement reasonable and appropriate safeguards to ensure that it uses and discloses Protected Health Information only for treatment, payment, health care operations, and other purposes permitted or required by the Privacy Rule.

  o Establish appropriate mechanisms to limit the use or disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use or disclosure.

  o Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties upon hire and at appropriate intervals thereafter and maintain appropriate documentation of such training.

  o Engage its business associates in business associate agreements that meet the requirements of the Privacy and Security Rules.

  o Make Protected Health Information available in accordance with 45 C.F.R. § 164.524; amend Protected Health Information and incorporate any amendments as required by 45 C.F.R. § 164.526; and account for disclosures of patients’ Protected Health Information as required by 45 C.F.R. § 164.528.

  o Provide patients with a notice of privacy practices in the manner and with the content required by the Privacy Rule, including information that informs patients of their privacy rights.

17.00 Sensitive Information

Provider must comply with the following requirements with respect to certain sensitive information:

A. Alcohol and Drug Abuse Treatment Records: When Provider receives information subject to the Federal Substance Abuse Rule (42 C.F.R. Part 2), Provider must comply with 42 C.F.R. Part 2, which generally prohibits re-disclosure without written consent. Note that a general written consent (including a HIPAA-compliant authorization) is not sufficient. In most cases, the following statement will accompany these records and must be included with such records when Provider discloses them to another party:

   This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.
Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B. Federal Tax Information (FTI): Any FTI made available to Provider must be used only for the purpose of carrying out the provisions of this Agreement. Federal Tax Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of the Provider is strictly prohibited.

Failure to comply with federal regulations regarding SSA, Medicaid, CHIP, and Substance Abuse, FTI, and PHI data may result in criminal and civil fines and penalties.
APPENDIX A - ADDITIONAL RESOURCES

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ www.DentaQuestgov.com. Once you have entered the website, click on “Tennessee” and then go to “Provider Resource Documents” to access the following resources:

ECF CHOICES Specific Forms:

- Malocclusion Severity Assessment Form
- Outpatient Hospital Readiness Form
- Provider Appeal Form
- Dental Member Appeal Form
- Member Unfair Treatment Complaint Forms
- Member Agreement to Pay Non-Covered Treatment

DentaQuest General Forms:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- 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 @ 855.418.1623.

You may also find copies of these forms within this manual.
ECF CHOICES Inpatient and Outpatient Hospital Readiness Pre-admission Form

This form is required to be submitted with documentation as outlined in Section 15.00, Criteria for Provision of Dental Treatment in an Inpatient/Outpatient Hospital ("Hospital") Facility or in an Ambulatory Surgical Center (ASC).

Patient Name ____________________ Patient ID # _______________ Patient Address __________________Date________

A. I certify that I have examined this patient
   ___YES ___NO Date of exam ___________

B. There is pathology or injury requiring extensive dental treatment (restorative or surgical)
   ___YES ___NO

C. I certify that I have attempted to treat this patient in my office
   ___YES ___NO Date ___________

D. If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)?
   ___YES ___NO

E. If no, why was a referral not made?

_________________________________________________________________________________________

E. I have attempted to treat the member with Silver Diamine Fluoride
   ___YES ___NO

F. Were x-rays taken to determine diagnosis?
   ___YES ___NO

H. I have submitted all of the documentation required to submit a request for prior authorization as described in the TennCare Office Reference Manual?
   ___YES ___NO

I. If answer to "G" or "H" is no, please explain why the aforementioned documentation is not being submitted:

_________________________________________________________________________________________

CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

Name of provider ____________________ Provider's signature _______________________ Date __________

Submit to:
DentaQuest – ECF Choices
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
FAX: 262.834.3452
ECF CHOICES Dental Provider Appeal Form

Member name: ______________________________________________
Member ID number: __________________________________________
Date of service: _____________________________________________
Date EOB received: __________________________________________
Authorization number: ________________________________________
Date authorization was received: ______________________________
Provider Name: _____________________________________________
Location Number: ___________________________________________
Office Contact: ______________________________________________
Office Phone Number: ________________________________________
Reason for Appeal: __________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Outcome office is requesting: ______________________________________
____________________________________________________________________________
____________________________________________________________________________

Submit to:
DentaQuest – ECF CHOICES
Attn: Provider Appeals
PO Box 2906
Milwaukee, WI  53201-2906
Fax: 262.834.3452
ECF CHOICES Dental Member Appeal Form

DENTAL APPEAL FORM
Use this page only to file an ECF CHOICES Dental Appeal.

Fill out front and back of this page. These are facts we must have to work your appeal. If you don’t tell us all the facts we need, we may not be able to decide your appeal. You may not get a fair hearing. Need help understanding what facts we need? Call us for free at 1-855-418-1622. If you call, we can also take your appeal by phone.

1. Who is the person that wants to appeal?

Full Name___________________________________________________________________________
Date of Birth_____/_____/_______                         Social Security Number_______- _______-_________
Or number on their TennCare Card_______________________________________________________
Current Mailing Address______________________________________________________________
City___________________________________________ State________ Zip Code_________________

The name of the person we should call if we have questions about this appeal:
____________________________________________________

A daytime phone number for that person (            ) _________-_________________________________

2. Who filled out this form?
If not the person who wants to appeal, tell us your name:_____________________________________

Are you a: □ Parent, relative, or friend   □ Advocate or attorney   □ Dentist or health care provider

3. What is the appeal for?
(Place an X in the box beside the best answer below)

□ Need care or medicine. (Fill out Part A on page 2.)

□ Have bills or paid for care or medicine you think ECF CHOICES should pay. (Fill out Part b on page 2.)

4. Do you think you have an emergency?
Usually, your appeal is decided within 90 days after you file it. But, if you have an emergency, you may not be able to wait 90 days. An emergency means if you don’t get care or medicine sooner than 90 days:

- You will be at risk of serious health problems or you may die.
- Or, it will cause serious problems with your heart, lungs, or other parts of your body.
- Or, you will need to go into the hospital.

Do you STILL think you have an emergency?
If so, you can ask ECF CHOICES for an emergency appeal. Your appeal may go faster if your doctor signs at the right saying that this appeal is an emergency. What if your doctor doesn't sign at the right, but you ask for an emergency appeal? ECF CHOICES will ask your doctor if your appeal is an emergency. If your doctor says it's not an emergency, ECF CHOICES will decide your appeal within 90 days. Some kinds of care are never treated as an emergency. To get a list of these kinds of care, ask TennCare.

If you want to ask ECF CHOICES for an EMERGENCY APPEAL, check this box. □

Your doctor can read and sign here to ask TennCare for an emergency appeal. I certify under penalty of perjury that I am the treating physician of the patient on behalf of whom this medical appeal is filed and that this appeal is an emergency. If this patient is required to wait 90 days for this care s/he is at risk of serious health problems or death, severe impairment of bodily organs or parts, or hospitalization. I understand that any intentional act on my part to provider false information is considered an act of fraud under the State’s TennCare Program & Title XIX of the Social Security Act.

Physician
Signature:________________________________________
Date:________________
5. Tell us why you want to appeal this problem. Include any mistake you think ECF CHOICES made. And, send copies of any papers that you think may help us understand your problem.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

To see which Part(s) you should fill out below; look at number 3 on page 1.

Part A. Need care or medicine. What kind - be specific
What’s the problem?
☐ Can’t get the care or medicine at all  ☐ The care or medicine is being cut or stopped
☐ Can’t get as much of the care or medicine that I need.  ☐ Waiting too long to get the care or medicine

Did your doctor prescribe the care or medicine?  ☐ Yes ☐ No  If yes, doctor’s name
_________________________________

Have you asked your health plan for this care or medicine?  ☐ Yes ☐ No  If yes, when?
What did they say?
______________________________________________________________________________________
______________________________________________________________________________________

Did you get a letter about this problem?  ☐ Yes ☐ No  If yes, the date of the letter
Who was the letter from?
______________________________________________________________________________________
______________________________________________________________________________________

Are you getting this care or medicine from ECF CHOICES now?  ☐ Yes ☐ No
Do you want to see if you can keep getting it during your appeal?  ☐ Yes ☐ No

Does your doctor say you still need it?  ☐ Yes ☐ No  If yes, doctor’s name
If you keep getting care or medicine during your appeal and you lose, you may have to pay ECF CHOICES back.

Part B. Bills for care or medicine you think ECF CHOICES should pay for
The date you got the care or medicine_____________________________________________________________________________
Name of doctor, drugstore, or other place that gave you the care or medicine_____________________________________________
Their phone number (          )__________ - ___________________________
Their address____________________________________________________________________________________
____________________________________________________________________________________

Did you pay for the care or medicine and want to be paid back?
☐ Yes ☐ No  If yes, you must send a copy of a receipt that proves you paid for the care or medicine.
If you didn’t pay, are you getting a bill?
☐ Yes ☐ No  If yes, and you think ECF CHOICES should pay, you must send a copy of a bill.
Tell us the date you first got the bill (if you know).
How to file your dental appeal
Then, mail these pages and other facts to:
TennCare Solutions  We do not allow unfair treatment in TennCare
PO BOX 593
Nashville, TN 37202-0593

Or, fax it (toll free) to 888-345-5575
Keep a copy of the page that shows your fax went through.
To appeal by phone, call 800-878-3192 for free.

Make a copy of the completed pages to keep.

Have speech or hearing problems?
Call our TTY/TDD line for free at 866-771-7043

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, disability. If you think you’ve been treated unfairly, call the Family Assistance Service Center for free at 800-878-3192.
Unfair Treatment Complaint
Version en espanol atras

Federal law says that unfair treatment is not allowed. No one can be treated in a different way because of race, color, birthplace, language, sex, age, beliefs or disability.
If you feel that you have been treated unfairly for any of these reasons, you have the right to complain. We do not allow unfair treatment in TennCare.
We need the following facts so we can look into your complaint. If you need help to fill out this page, let us know.

1. Are you filing this complaint for yourself?  Yes ☐ No ☐
   If yes, go to question number 2.
   If no, tell us your name: ______________________________________________________
   Give us a phone number where we can reach you: (_________ ) _____________________

2. What is the name of the person you feel was treated unfairly?
   | Name of Person You Feel Was Treated Unfairly | Date of Birth |
   | Last | First | Middle Initial | Month / Day / Year |
   | Full Mailing Address: |
   | Street Number and Name, Rural Route, Apt Number, Lot Number, PO Box, etc. |
   | City: | State: | Zip: | Social Security Number: |
   | Daytime Phone (_________ ) ----------- | Evening Phone (_________ ) |

3. Who do you think treated this person unfairly?
   Name__________________________________________________________________________
   Address ________________________________________________________________________
   City, State, and Zip Code ____________________________
   Phone Number (_________ ) ____________________________ - or - (_________ ) ____________

   Check the box or boxes that you think were the reason for the unfair treatment.
   Race ☐ Color ☐ Birthplace ☐ Language spoken ☐ Sex ☐
   Religion ☐ Beliefs ☐ Age ☐ Disability ☐
   What date did the unfair treatment take place? ________________________________________
   Do you think it has happened other times? ☐ Yes ☐ No If yes, how many other times? _______
   Have you complained about this problem before and tried to have it stopped? ☐ Yes ☐ No
   If yes, who have you talked to about it? Name: _______________________________________
   When did you talk to them about it? ____________________________
   Have you filed this complaint with another federal, state, or local agency? ☐ Yes ☐ No
   Have you filed this complaint with any federal or state court? ☐ Yes ☐ No
   If yes, check all that apply. Federal agency ☐ Federal court ☐
   State agency ☐ State court ☐ Local agency ☐
   If yes, tell us the name of the contact person at the agency/court where you filed the complaint.
   Name: __________________________________________________________________________
DentaQuest of Tennessee, LLC

Agency/Court Name __________________________________________________________________
Address ____________________________________________________________________________
City, State, and Zip Code ______________________________________________________________
Phone Number (________ ) ________________________________________________________

5. In your own words, tell us what happened. You can attach more pages if you need them.
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Please sign below. Attach any other information that you think will be helpful.

Sign here. X ___________________________ Date: ______________

If you filled out this page for someone else, sign here. X ___________________________
(Note: if you helped someone file this complaint, you do not have to sign it.)

Print your name: ___________________________ Date: ______________

Mail these pages to: DentaQuest -TennCare
Attn: Office of Non-discrimination Compliance
PO Box 2906
Milwaukee, WI  53201-2906

For TTY please call: (Toll-free) 711 (800) -466-7566 for help.

If you have questions or need to get help in another language, please call: (855) 418-1622 or you may call one of the following numbers.

<table>
<thead>
<tr>
<th>Language</th>
<th>Toll Free Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Bosnian</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Kurdish-Badinani</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Kurdish-Sorani</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Somali</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Spanish</td>
<td>1-800-758-1638</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1-800-758-1638</td>
</tr>
</tbody>
</table>

ECF CHOICES does not allow unfair treatment based on race, color, language spoken, sex, sexual orientation, religion, handicap/disability or age.
You have a right to fair treatment.

If you think you have been treated unfairly, this page tells you who to contact.

We do not allow unfair treatment in TennCare.
State and Federal laws protect you from unfair treatment
No one can treat you in a different way because of your:

- Race
- Birthplace
- Sex
- Beliefs
- Disability
- Color
- Language
- Religion
- Age

In TennCare, unfair treatment could mean many things. It could mean someone treated you differently because of one of the things listed above. For example:
- Maybe they didn’t let you take part in the same things as other people.
- Maybe you did not get the help you needed to get health care.
- Maybe you did not get the health care that you needed.

Do you think you have been treated unfairly? You may contact any of the places listed below for help.
You also have the right to file a complaint. By law, no one can get back at you for filing a complaint.

This is who you can contact if you are treated unfairly under TennCare.

<table>
<thead>
<tr>
<th>Is your problem with your:</th>
<th>U.S. Department of Health &amp; Human Services - Office for Civil Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical health care? Then call your health plan MCO.</td>
<td>You can call (800) 368-1019 for free.</td>
</tr>
<tr>
<td>• Mental health care? Then call your MCO.</td>
<td>You can write to:</td>
</tr>
<tr>
<td>• Dental care? Then call DentaQuest.</td>
<td>Director - Office for Civil Rights</td>
</tr>
<tr>
<td>Call their Member Services Line.</td>
<td>U.S. Department of Human Services</td>
</tr>
<tr>
<td>The number is listed in your Member Handbook.</td>
<td>200 Independence Ave., S W -Room 506</td>
</tr>
<tr>
<td>Ask to speak with the Non-discrimination</td>
<td>F</td>
</tr>
<tr>
<td>Compliance Coordinator.</td>
<td>Washington, DC 20201</td>
</tr>
<tr>
<td>Bureau of TennCare</td>
<td>TDD: (800) 537-7697</td>
</tr>
<tr>
<td>You can call the Office of Non-discrimination at:</td>
<td>U.S. Department of Health &amp; Human Services - Region IV Office for Civil Rights</td>
</tr>
<tr>
<td>(615) 507-6474.</td>
<td>You can call:</td>
</tr>
<tr>
<td>You can call for free at (855) 857-1673.</td>
<td>Director - Office for Civil Rights</td>
</tr>
<tr>
<td>You can write to:</td>
<td>U.S. DHHS / Region IV Office for Civil Rights</td>
</tr>
<tr>
<td>Bureau of TennCare</td>
<td>61 Forsyth Street, SW - 3rd Floor, Suite 3870</td>
</tr>
<tr>
<td>310 Great Circle Road</td>
<td>Atlanta, GA 30303</td>
</tr>
<tr>
<td>Nashville, TN 37247</td>
<td>Fax: (404) 562-7881</td>
</tr>
<tr>
<td>Fax: (615) 253-2917</td>
<td>TTYRC - Tennessee Title VI Compliance Program</td>
</tr>
<tr>
<td>TTY: Toll Free - 1-877-779-3103</td>
<td>You can call (615) 532-4882.</td>
</tr>
<tr>
<td></td>
<td>You can write to:</td>
</tr>
<tr>
<td></td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td>Andrew Johnson Tower -1st Floor</td>
</tr>
<tr>
<td></td>
<td>710 James Robertson Parkway</td>
</tr>
<tr>
<td></td>
<td>Nashville, TN 37243-0635</td>
</tr>
<tr>
<td></td>
<td>Fax: (615) 253-1886</td>
</tr>
</tbody>
</table>
**Agreement to Pay Non-Covered Services**

Patient Name: ____________________________________________

Member(Medicaid) ID: ______________________________________

Guarantor Name: __________________________________________

Relationship to Patient: ____________________________________

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand that the above services are not covered by the ECF CHOICES Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

Guarantor Signature ____________________________ Date ________

Guarantor Address: ________________________________

Street, Apt # ________________________________

City, State, Zip ________________________________

Guarantor Phone ________________________________

Home: ________________________________

Cell: ________________________________

Work: ________________________________
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/npi

**ADDITIONAL PROVIDER IDENTIFIER**

52A and 58

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

**PROVIDER SPECIALTY CODES**

56A

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

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>1223000006X</td>
</tr>
<tr>
<td>General Practice (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>1223D0001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E000X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X000X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P002X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P000X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P001X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P006X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S011X</td>
</tr>
</tbody>
</table>

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:

www.wpc-edl.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
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 ____________________________________________

<table>
<thead>
<tr>
<th>OK</th>
<th>OK</th>
<th>CLINICAL FINDINGS/COMMENTS</th>
</tr>
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<tbody>
<tr>
<td>LYMHP NODES</td>
<td>TMJ</td>
<td></td>
</tr>
<tr>
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<td>TONGUE</td>
<td></td>
</tr>
<tr>
<td>TONSILS</td>
<td>VESTIBULES</td>
<td></td>
</tr>
<tr>
<td>SOFT PALATE</td>
<td>BUCCAL MUCOSA</td>
<td></td>
</tr>
<tr>
<td>HARD PALATE</td>
<td>GINGIVA</td>
<td></td>
</tr>
<tr>
<td>FLOOR OF MOUTH</td>
<td>PROSTHESIS</td>
<td></td>
</tr>
<tr>
<td>LIPS</td>
<td>PERIO EXAM</td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td>ORAL HYGIENE</td>
<td></td>
</tr>
<tr>
<td>RADIOGRAPHS</td>
<td>B/P</td>
<td>RDH/DDS</td>
</tr>
</tbody>
</table>

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 ____________________________________________

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</table>

R WORK NECESSARY    L

TOOTH  1  2  3  4  5  6  7  8  9  10  11  12  13  14  15  16
SERVICE

TOOTH  32  31  30  29  28  27  26  25  24  23  22  21  20  19  18  17
SERVICE

COMMENTS: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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

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

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

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

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

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

Procedure(s): _________________________________________________________________

Tooth Number(s):  ______________________________________________________________

Date:  _____________________________________

Dentist:  __________________________________

Patient Name:  _____________________________

Legal Guardian/
Patient Signature:  ___________________________

Witness:  __________________________________

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.
AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS
DISBURSED BY DENTAQUEST OF TENNESSEE, LLC

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

MAINTENANCE TYPE:

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

ACCOUNT HOLDER INFORMATION:

Account Number: ______________________________________________________________________

Account Type: __________ Checking

__________ Personal __________ Business (choose one)

Bank Routing Number:

Bank Name: ____________________________________________________________________________

Account Holder Name: ___________________________________________________________________

Effective Start Date: _____________________________________________________________________

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

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

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

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

____________________________________   __________________________________________
Date      Print Name

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

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

________________________________________________
Tax Id (As appears on W-9 submitted to DentaQuest)
MEDICAL AND DENTAL HISTORY

Patient Name: _________________________________ Date of Birth: ___________________

Address: _____________________________________________________________________

Why are you here today? _______________________________________________________________________

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

If yes, what type and where? _______________________________________________________________________

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

Medical Doctor’s Name: _______________________________________________________________________

Address: _______________________________________________________________________

Telephone: _______________________________________________________________________

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

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

If yes, please list medications: _______________________________________________________________________

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

If yes, please list: _______________________________________________________________________

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

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

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

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

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

Are you on a special diet? □ Yes □ No

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

If yes, where? _______________________________________________________________________

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

If yes, how often and how much? _______________________________________________________________________

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? □ Yes □ No
Do you have or have you had any disease, or condition not listed?  □ Yes  □ No

If yes, please list: ____________________________________________________

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

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

For Women Only:
Are you pregnant?  □ Yes  □ No
If yes, what month? __________________
Are you nursing?  □ Yes  □ No
Are you taking birth control pills?  □ Yes  □ No

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

Patient Signature: ___________________________ Date: _______________________

Dentist’s Signature: ___________________________ Date: _______________________

Review Date | Changes in Health Status | Patient’s signature | Dentist’s signature |
-------------|--------------------------|---------------------|---------------------|
-------------|--------------------------|---------------------|---------------------|

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

You may send this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077

**Section 1: Current Information - Complete for ALL Requests - Asterisk denotes required fields**

<table>
<thead>
<tr>
<th>Change Effective Date (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Provider Last Name</td>
</tr>
<tr>
<td>*Individual National Provider Identifier (NPI) #</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>*Specialty</td>
</tr>
</tbody>
</table>

**Requestor Information**

<table>
<thead>
<tr>
<th>*Requestor Name</th>
<th>*Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Requestor Contact Information (Phone or E-mail)</td>
<td></td>
</tr>
</tbody>
</table>

**Section 2: Type of Update - Check all that Apply - Complete for ALL Requests - For Questions contact your Provider**

- Business (Tax ID) - Add/ Term/ Update - Complete Sections 1, 7 and 8
- Credentialing Correspondence Change/Update - Complete Sections 1 and 5
- EFT/ Payment - Complete Sections 1 and 8
- License Change - Complete Sections 1 and 4
- Name Change - Complete Sections 1 and 3
- Location - Add/ Term/ Update - Complete Sections 1 and 6
- Termination Request - Complete Sections 1 and 9

**Section 3: Name Change - Attach supporting legal documentation**

<table>
<thead>
<tr>
<th>New Last Name</th>
<th>New First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Middle Name</td>
<td>New Suffix</td>
</tr>
</tbody>
</table>

**Please Note:** Before DentaQuest can change your name in our system, your license must reflect the name change.

**Section 4: License Change**

<table>
<thead>
<tr>
<th>New Dental License Number</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>New DEA License Number</td>
<td>State</td>
</tr>
<tr>
<td>New State Drug License Number</td>
<td>State</td>
</tr>
<tr>
<td>New Medicaid License Number</td>
<td>State</td>
</tr>
<tr>
<td>Other License Name</td>
<td>State</td>
</tr>
<tr>
<td>Other License Number</td>
<td>State</td>
</tr>
</tbody>
</table>

**Section 5: Credentialing Correspondence Change**

<table>
<thead>
<tr>
<th>Credentialing Contact Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correspondence Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Credentialing E-Mail</td>
</tr>
</tbody>
</table>

A-92
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

This section identifies ECF CHOICES Program covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations. Providers with benefit questions should contact DentaQuest’s Customer Service Department directly at:

855.418.1622

Dental offices are not allowed to charge ECF CHOICES Members for missed appointments. ECF CHOICES 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 number “1” to “32” for permanent teeth. Supernumerary teeth should be designated by “AS through TS” for numbers “51” to “82” for permanent teeth. These codes must be referenced in the patient’s file for record retention and review. All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

For reimbursement, ECF CHOICES Providers should bill only per unique surface regardless of location. For example, when a dentist places separate restorations in both occlusal pits on an upper permanent first molar, the billing should state a one surface occlusal amalgam ADA coded 2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (e.g. 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 in this manual. 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 table (Exhibit A) is all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. 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, and
6. any other applicable benefit limitations.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Procedure Code Description</th>
<th>Rate</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral exam</td>
<td>$24.40</td>
<td>Exam</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation</td>
<td>$24.40</td>
<td>Exam</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation</td>
<td>$29.25</td>
<td>Exam</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation</td>
<td>$41.93</td>
<td>Exam</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited</td>
<td>$24.40</td>
<td>Exam</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - complete series</td>
<td>$62.39</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical 1st film</td>
<td>$12.68</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional</td>
<td>$9.75</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film</td>
<td>$12.68</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - 1st film</td>
<td>$14.63</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0251</td>
<td>Extraoral – posterior dental radiographic image</td>
<td>$14.62</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single film</td>
<td>$11.70</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewing - two films</td>
<td>$18.53</td>
<td>Procedure</td>
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<tr>
<td>D0273</td>
<td>Bitewing - three films</td>
<td>$23.40</td>
<td>Procedure</td>
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<tr>
<td>D0274</td>
<td>Bitewing - four films</td>
<td>$28.28</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 films</td>
<td>$39.00</td>
<td>Procedure</td>
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<tr>
<td>D0322</td>
<td>Tomographic survey</td>
<td>$341.22</td>
<td>Procedure</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>$49.73</td>
<td>Procedure</td>
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<tr>
<td>D0340</td>
<td>Cephalometric film</td>
<td>$58.49</td>
<td>Procedure</td>
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<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>$29.25</td>
<td>Procedure</td>
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<td>D0470</td>
<td>Diagnostic casts</td>
<td>$53.62</td>
<td>Procedure</td>
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<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>$43.88</td>
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<td>D1206</td>
<td>Fluoride varnish</td>
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<td>Topical Fluoride</td>
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<td>Silver Diamine Fluoride- Interim caries arresting medicament</td>
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<tr>
<td>D2140</td>
<td>Amalgam - 1 surface</td>
<td>$63.44</td>
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<tr>
<td>D2150</td>
<td>Amalgam - 2 surface</td>
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<tr>
<td>D2160</td>
<td>Amalgam - 3 surface</td>
<td>$86.84</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - 4+ surface</td>
<td>$92.69</td>
<td>Procedure</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Amount</td>
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<tr>
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<td>Composite - 1 surf anterior</td>
<td>$63.44</td>
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<tr>
<td>D2331</td>
<td>Composite - 2 surf anterior</td>
<td>$76.12</td>
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<tr>
<td>D2332</td>
<td>Composite - 3 surf anterior</td>
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<td>D2335</td>
<td>Composite - 4+ surf anterior</td>
<td>$92.69</td>
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<tr>
<td>D2390</td>
<td>Composite crown - anterior - permanent tooth</td>
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<tr>
<td>D2391</td>
<td>Composite - 1 surf posterior - permanent tooth</td>
<td>$63.44</td>
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<td>D2393</td>
<td>Composite - 3 surf posterior - permanent tooth</td>
<td>$86.84</td>
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<tr>
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<td>Composite - 4+ surf posterior - permanent tooth</td>
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<td>Crown – resin-based composite (indirect)</td>
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<td>D2721</td>
<td>Crown - resin/metal base</td>
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<td>D2722</td>
<td>Crown - resin/metal noble</td>
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<td>D2740</td>
<td>Crown - porc/ceramic</td>
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<td>Crown-proc/metal high noble</td>
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<td>D2751</td>
<td>Crown - porc/metal base</td>
<td>$538.15</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porc/metal noble</td>
<td>$538.15</td>
<td>Procedure</td>
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<tr>
<td>D2781</td>
<td>Crown - 3/4 metal base</td>
<td>$538.15</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown - 3/4 metal noble</td>
<td>$538.15</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - 3/4 porc/ceramic</td>
<td>$538.15</td>
<td>Procedure</td>
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<tr>
<td>D2791</td>
<td>Crown - full metal base</td>
<td>$538.15</td>
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<tr>
<td>D2792</td>
<td>Crown - full metal noble</td>
<td>$538.15</td>
<td>Procedure</td>
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<tr>
<td>D2920</td>
<td>Recement crown</td>
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<td>Procedure</td>
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<tr>
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<td>Crown - stainless steel permanent</td>
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<td>Procedure</td>
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<td>D2932</td>
<td>Crown - prefab resin</td>
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<td>D2933</td>
<td>Crown - stainless steel w/ window</td>
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<td>D2940</td>
<td>Sedative filling</td>
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<tr>
<td>D2950</td>
<td>Core buildup w/ pins</td>
<td>$126.74</td>
<td>Procedure</td>
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<tr>
<td>D2951</td>
<td>Pin retention - per tooth</td>
<td>$35.10</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2952</td>
<td>Cast post and core</td>
<td>$165.73</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2953</td>
<td>Each additional cast post</td>
<td>$106.27</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefab post and core</td>
<td>$165.73</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2955</td>
<td>Post removal</td>
<td>$82.87</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2957</td>
<td>Each additional prefab post</td>
<td>$87.74</td>
<td>Procedure</td>
</tr>
<tr>
<td>D2980</td>
<td>Crown repair</td>
<td>$43.88</td>
<td>Procedure</td>
</tr>
<tr>
<td>D3220</td>
<td>Pulpotomy</td>
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<td>Procedure</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Rate</td>
<td>Type</td>
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<tr>
<td>D3221</td>
<td>Gross pulpal debridement</td>
<td>$85.79</td>
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<tr>
<td>D3310</td>
<td>Root canal - anterior</td>
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<td>Procedure</td>
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<td>D3320</td>
<td>Root canal - bicuspid</td>
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<tr>
<td>D3330</td>
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<td>$505.98</td>
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<tr>
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<td>Treatment of root canal obstruction</td>
<td>$127.72</td>
<td>Procedure</td>
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<tr>
<td>D3332</td>
<td>Incomplete endodontic therapy</td>
<td>$141.37</td>
<td>Procedure</td>
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<tr>
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<td>Therapeutic drug injection</td>
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<td>Other drugs/meds, by report</td>
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<td>Occlusal guard</td>
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<td>Odontoplasty – 1 to 2 teeth</td>
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