# DQ National Insurance Company, Inc.

# Office Reference Manual

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

# AmeriHealth Caritas Delaware

## Medicaid Children's Dental Program

## Medicaid Adults (21 and Over)

**PO Box 2906**

**Milwaukee, WI 53201-2906**

855.343.7403

www.dentaquest.com

*DentaQuest LLC March 26, 2025*

## Address and Quick Reference Telephone Numbers

**DentaQuest Provider Services:**
1.855.343.7403

**DentaQuest Member Services:**
1.833.955.3421

**AmeriHealth Caritas DE Medicaid Member Services:**
1.844.211.0966

**TTY (Hearing Impaired):**
711

**Fraud Hot-line**
1.800.237.9139

**DentaQuest Member and Provider Website:**
www.dentaquest.com/en/providers/delaware

**Authorizations (send to):**
DentaQuest - Authorizations
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 1.262.241.7150 or 1.888.313.2883

**Credentialing Applications (send to):**
DentaQuest - Credentialing
PO Box 2906
Milwaukee, WI 53201-2906

**Credentialing Hot-line:** 1.800.233.1468
Fax: 1.262.241.4077

**Claims (send to):**
DentaQuest - Claims
PO Box 2906
Milwaukee, WI 53201-2906

**Electronic Claims (send to):**
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

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# Statement of Members Rights and Responsibilities

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

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

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

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

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

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

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

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

8. All Members have the right to ask that a specific Provider be added to the participating network.

9. All Members have the right to request and receive a copy of your medical /dental records and to request that they be changed or corrected.

10. All Members have the right to exercise your rights without being treated differently.

11. All Members have the right to be free from any form of restraint or seclusion used to convince you to do something you may not want to do, or as punishment.

Likewise:

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

2. All Members have a responsibility to closely follow the treatment plans and home care instructions for

the care that they have agreed upon with their health care practitioners.

3. All Members have the responsibility to participate in understanding their health problems and

developing mutually agreed upon treatment goals to the degree possible.

4. All Members have the responsibility to know their medications and inform the Provider of their medication.

5. All Members have the responsibility to make sure to understand information and instructions given by your Provider.

6. All Members have the responsibility to be courteous to the Provider and to other patients by arriving 10 minutes early for their appointment and to call the dental office at least 24 hours in advance if they cannot keep their appointment.

# Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.
2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the Participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

* * *

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

## 1.00 Patient Eligibility Verification Procedures

### 1.01 Plan Eligibility

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

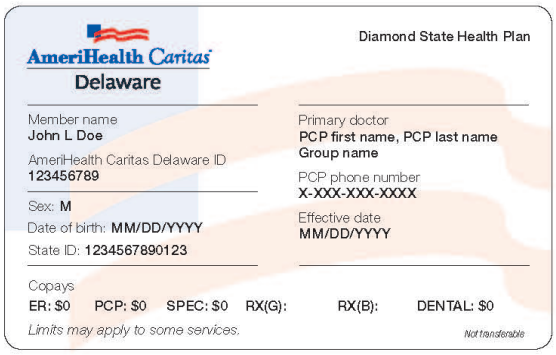
### 1.02 Member Identification Card

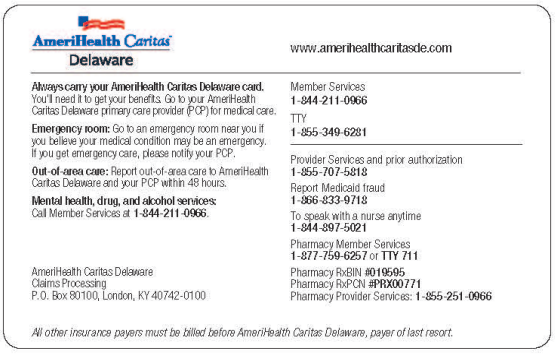
Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

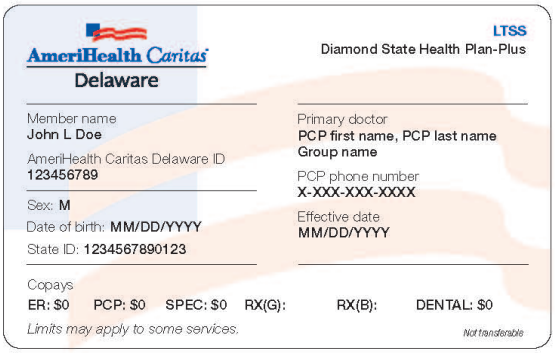
Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

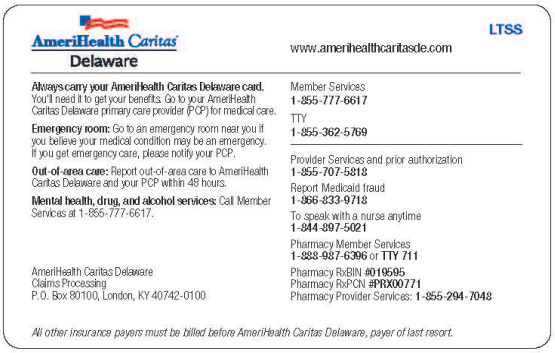
DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a member lose eligibility. Therefore,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

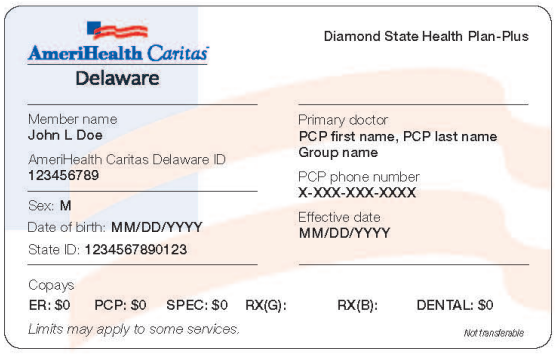
**Sample of AmeriHealth Caritas Delaware Plan ID Cards:**

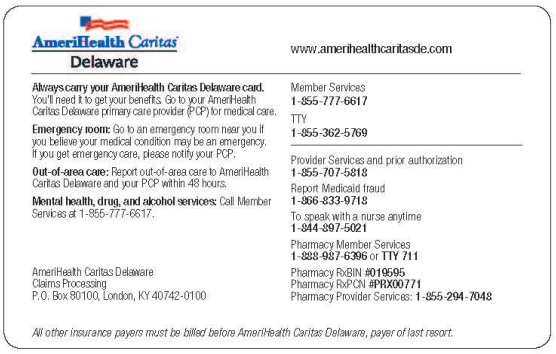


### 1.03 State Member Eligibility

Dental services are covered for adults age 21 and above.

It is the provider's responsibility to verify an individual's current eligibility each time a service is provided. The provider should request that the individual show a current Medical Assistance Card and identification for the patient to establish identity and to determine whether the individual is enrolled in the FFS program or with one of the contracted MCOs. Eligibility can be verified via the Delaware Medical Assistance Portal for Providers (Provider Portal) during an individual's FFS period; or through the MCO Provider Portal to which the individual is assigned.

Eligibility can be verified via the Delaware Medical Assistance Portal for Providers (Provider Portal) or by calling the DMAP Fiscal Agent at 1-800-999-3371, Option 1 for the automated voice response system. To speak with a provider service representative, contact the DMAP Fiscal Agent at 1-800-999-3371, Option 0, Option 2.

### 1.04 DentaQuest Eligibility Systems

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

**Access to eligibility information via the Internet**
DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at **www.dentaquest.com**. Once you have entered the website, click on "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and ZIP code. If you have not received instruction on how to complete Provider Self Registration, contact DentaQuest's Customer Service Department.

Once logged in, select "Eligibility look up" and enter the applicable information for each Member you are inquiring about.

You can check on an unlimited number of patients and 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 and press 1 for eligibility. The IVR system will be able to answer all your eligibility questions for as many members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid member by entering your six-digit DentaQuest location number, the member's recipient identification number and an expected date of service. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the member information you entered, you will be transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service.
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 four digits of your Tax ID number. Does the
6. 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
9. claim history on this member, or get fax confirmation of this call.
   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 have trouble accessing either the IVR or website, please contact the Customer Service Department for further assistance.

## 2.00 Authorization for Treatment

### 2.01 Dental Treatment Requiring Authorization

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

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

**A. Authorization and documentation submitted before treatment begins (Non-emergency) treatment.**

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

Your submission of "documentation" should include:

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

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

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

### B. Submitting Authorization Requests and X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member's name, identification number and office name to ensure proper handling.

### C. Authorization and documentation submitted with claim (Emergency treatment)

DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

### 2.02 Payment for Covered and Non-Covered Services

## Plan Reimbursement Policy:

(a) Compensation of Participating Practice by DentaQuest is subject to, and dependent upon, DentaQuest's receipt of proper claims payment from Plan. In the event of nonpayment by Plan, DentaQuest reserves the right to withhold or recover payment to Participating Practice for all claims not paid by Plan. If and when DentaQuest has received the outstanding amount for such claims from Plan, DentaQuest will reimburse Participating Practice according to the terms of the Provider Agreement.

(b) Fee Schedule. Participating Practice shall be compensated in accordance with the applicable fee schedule that corresponds to plan/product type.

(c) Continuation of care: Participating Practice agrees to complete any treatment in progress for continuation of care cases and cases in mid-treatment for a newly enrolled member. DentaQuest agrees to negotiate fees in good faith for partial cases/ treatments.

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

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

### 2.03 Electronic Attachments

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

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

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

800.782.5150

### 2.04 Dispute Resolution/Provider Appeals Procedure

Participating Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This notice *and* additional support information must be sent to DentaQuest within 60 days from the date of the original determination to be reconsidered by DentaQuest's Peer Review Committee.

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

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

## 3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Provider should submit dental services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should contact Health Plan for facility authorization at the number below.

Health Plan: 1.844.211.0966, TTY 1.855.349.6281

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

## 4.00 Claim Submission Procedures (Claim Filing Options)

DentaQuest receives dental claims in 4 possible formats. These formats include:

- Electronic claims via DentaQuest's website (**www.dentaquest.com**)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims via U.S. Postal Service or Fax **1.262.834.3589**

### 4.01 Submitting Claims with X-Rays

- Electronic submission using the Provider Web Portal (PWP)
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit **www.nea-fast.com** and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are five or more radiographs submitted at one time. If five or more radiographs are submitted and not mounted, they will be returned to you and your claims will not be processed. You will need to resubmit a copy of the 2024 ADA claim form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include Member's name, identification number and office name to ensure proper handling.

### 4.02 Electronic Claim Submission Utilizing DentaQuest's Internet Website

**(Provider Web Portal)**

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our Provider Web Portal. 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 portal, simply log on to **www.dentaquest.com**. Once you have entered the website, click on the "Dentist" icon. From there choose your State and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Provider Service Department at **1.855.343.7403.** Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Provider 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 portal, please contact our Systems Operations at **1.800.417.7140** or via e-mail at **EDITeam@greatdentalplans.com**

### 4.03 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (**1.888.255.7293**), Tesia (**1.800.724.7240**), EDI Health Group (**1.800.576.6412**), Secure EDI (**1.877.466.9656**), and Mercury Data Exchange (**1.866.633.1090**) for claim submissions to DentaQuest.

You can contact your software vendor to 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 Payer ID is CX014.

### 4.04 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** to ask about this option for electronic claim submission.

### 4.05 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards 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 **https://nppes.cms.hhs.gov/NPPES/Welcome.do** and provide this information to DentaQuest in its entirety.
- All Providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.

- 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 NPIs. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

### 4.06 Paper Claim Submission

- Claims must be submitted on a 2024 ADA claim form; and other forms as approved in advance by DentaQuest.
- Member name, identification number and date of birth must be listed on all claims submitted. If the Member ID number is missing or miscoded on the claim form, the Member 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 Provider signature is used for identification, the Provider's name cannot be clearly identified. Please include either a typed Provider (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid Provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The 2024 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 Provider who provided the treatment. For example, on a standard 2024 ADA Dental Claim Form, the treating Provider'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 manual 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:

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

Or Fax to **1.262.834.3589**

**EMERGENCY Treatments and Authorizations**

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

Please FAX this to 1.262.241.7150.

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

### 4.07 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 Coordination of Benefits (COB) field. When a primary carrier's payment meets or exceeds a Provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

### 4.08 Filing Limits

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

Timely filing for AmeriHealth Caritas Delaware Medicaid Program claim submission is 120 days from the date of service. For dental services, the timely filing calculation is from the date of each service (line item).

### 4.09 Receipt and Audit of Claims

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

Each DentaQuest Provider office receives an Explanation of Benefit (EOB) report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

### 4.10 Payment for Covered Services

A covered benefit is as defined in the Covered Services Benefit Tables in the AmeriHealth Caritas Delaware Medicaid Office Reference Manual (ORM) Appendix B, Exhibits. Covered dental services may be limited to maximum number of units allowable per day, frequency limitation, prior authorization requirements, or other reporting requirements.

A valid CDT procedure code is required for billing dental services provided to Medicaid-eligible adults aged 21 and over. Refer to the Covered Services Benefit Tables found in Appendix B of the AmeriHealth Caritas Delaware Medicaid Office Reference Manual (ORM) for CDT Code Coverage Guidelines. When billing for dental services, the appropriate diagnosis must be maintained in the individual's treatment record.

Before rendering services, providers should reference Appendix B, which lists the program's coverage guidelines for dental services. These guidelines include whether a service is covered frequency, and quantity limitations for each service and prior authorization and reporting requirements. Providers should verify an individual's treatment history related to services with frequency limitations prior to providing service.

As described in the General Policy Manual, individuals may not be billed for services. Providers must not collect money in advance when primary insurance pays the individual directly. When the third-party reimbursement is made directly to the individual, the provider may bill the individual in order to obtain the third-party payment. Only the amount of the third-party payment and a copy of the insurer's explanation of benefits can be obtained.

- A covered benefit is as defined in the Covered Services Benefit Tables in the AmeriHealth Caritas Delaware Medicaid Office Reference Manual (ORM) Appendix B, Exhibits.
- Participating Providers may not assert a lien on any money, settlement, recovery or judgment paid to the Member or to the Member's estate as the result of personal injury lawsuit.
- Constraints against billing Members for benefit services apply whether or not DentaQuest makes or has made payment and whether or not the Provider participates in the DentaQuest Provider Network.
- Participating Providers may not bill DentaQuest for missed appointments, telephone calls, completion of claim forms or medication refill approvals.
- Members may not be billed if the failure to obtain claim payment from DentaQuest is caused by the Participating Provider's failure to comply with the DentaQuest program billing procedures.
- Collections agencies cannot submit DentaQuest claims for payment and cannot collect payment from a Member.

### 4.11 Billing Instructions for Supernumerary Tooth

**Bill**: Use CDT code D7999

Enter the total number of units (when more than one supernumerary tooth is extracted the same day, increase the number of units). DO NOT BILL additional CDT Codes for supernumerary extractions on another line.

**Fee**: Include the fee for the service (When more than one tooth is extracted the same day, add the cost of all extracted supernumerary teeth.) Additional Comments: Enter CDT code for type of extraction in comment box add D7140, D7210, etc. Also note in the box on the claim where the tooth/teeth are located.

**Example**: D7999 units 3 total cost $350.00 (D7210 $150.00, D7140 $100.00 each) Additional Comments: between 8, 9, 24, 25, 6, 7 (D7210 2@D7140).

### 4.12 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 at **www.dentaquest.com**.
Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
Return the Direct Deposit Authorization Form and voided check to DentaQuest.

- Fax: **1.262.241.4077 or**
- Mail: **DentaQuest**
  **ATTN: Standard Updates**
  **PO Box 2906 Milwaukee,**
  **WI 53201-2906**

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

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

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

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

## 5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at **1.855.343.7403** or via e-mail at **denelig.benefits@dentaquest.com**.

### 5.01 Use of Provider Information

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

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 1.855.343.7403 or via e-mail at denelig.benefits@dentaquest.com.

### 5.02 HIPAA Companion Guide

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

## 6.00 Inquiries, Grievances and Appeals

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

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

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

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

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

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

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

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

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

**DentaQuest**
**ATTN: Provider Grievances**
**PO Box 2906**
**Milwaukee, WI 53201-2906**

All **Member** grievances should be sent to:

**AmeriHealth Caritas Delaware**
**ATTN: Complaints and Grievances Department**
**PO Box 80102**
**London, KY 40742-0102**

**Appeal:** An appeal is a verbal or written request for a review of an adverse benefit determination taken by DentaQuest. A request for review of a decision that results in any of the following actions:

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

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

**All pre-service appeals should be sent to:**

**AmeriHealth Caritas Delaware**
**PO Box 80102**
**London, KY 40742-0102**

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

**All post-service appeals should be sent to:**

**DentaQuest**
**ATTN: Provider Appeals**
**PO Box 2906**
**Milwaukee, WI 53201-2906**

**Expedited Appeal:** Expedited Appeals are provided upon request of the provider, the Member or their authorized representative if it is established that a delay would seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request.

**All expedited appeals should be sent to:**

**AmeriHealth Caritas Delaware**
**PO Box 80102**
**London, KY 40742-0102**

## 7.00 Utilization Management Program

### 7.01 Introduction

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

### 7.02 Community Practice Patterns

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

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

### 7.03 Evaluation

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

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

### 7.04 Results

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

## 8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes:

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

A copy of DentaQuest's QI Program is available upon request by calling DentaQuest's Customer Service Department or via e-mail at **denelig.benefits@dentaquest.com**.

## 9.00 Credentialing (Policies 300 Series)

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

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

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

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

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

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

**Discipline of Providers (Policy 300.019)**

**Procedures for Discipline and Termination (Policies 300.017-300.021)**

**Recredentialing (Policy 300.016)**
Network providers are recredentialed at least every 24 months.

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

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## 10.00 The Patient Record

### A. Organization

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

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

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

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

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

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

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

### B. Content – The patient record must contain the following:

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

    a. Patient's first and last name.
    b. Date of birth.
    c. Sex.

d. Address.
e. Telephone number.
f. Name and telephone number of the person to contact in case of emergency.

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

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

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

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

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

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

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

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

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

a. Blood pressure. (Recommended)
b. Head/neck examination.

c. Soft tissue examination.
d. Periodontal assessment.
e. Dentition charting.

7. Radiographs which are:

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

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

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

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

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

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

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

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

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

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

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

a. Date of service/procedure.
b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by

tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
c. Type and dosage of anesthetics and medications given or prescribed.
d. Localization of procedure/observation. (tooth number, quadrant etc.)
e. Signature of the Provider who rendered the service.

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

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

### C. Compliance

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

## 11.00 Patient Recall System Requirements

### A. Recall System Requirement

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

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

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

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

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

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

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

**B. Office Compliance Verification Procedures**

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
  - Emergency care appointments must be available within 24 hours.
  - Urgent care appointments must be available within two calendar days.
  - Routine care appointments must be available within three weeks of member request.

## 12.00 Radiology Requirements

**Note**: Please refer to benefit tables for radiograph benefit limitations.

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

**A. Radiographic Examination of the New Patient**

1. Adult – dentulous

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

2. Adult – edentulous

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

**B. Radiographic Examination of the Recall Patient**

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

   a. Adult – dentulous

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

   b. Adult – edentulous

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

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

   a. Adult – dentulous

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

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

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

4. Growth and Development Assessment

   a. Adult

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

## 13.00 Clinical Criteria

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

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

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

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

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required

documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization, and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the “Review Required” column.

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

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

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

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

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

### 13.01 Criteria for Medical Immobilization* Including Restraint Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient’s record should include:

**13.01.1** informed consent;
**13.01.2** type of immobilization used;
**13.01.3** indication for immobilization;
**13.01.4** the duration of application.

**Indications*:**

**13.01.4.1** patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to lack of maturity;
**13.01.4.2** patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to a mental or physical disability;
**13.01.4.3** when he safety of the patient and/ or practitioner would be at risk without the protective use of immobilization.

**Contraindications*:**

**13.01.4.4** cooperative patient;
**13.01.4.5** patient who cannot be immobilized safely due to associated medical conditions.

**Goals of Behavior Management*:**

**13.01.4.6** establish communication;

**13.01.4.7** alleviate fear and anxiety;

**13.01.4.8** deliver quality dental care;

**13.01.4.9** build a trusting relationship between dentist and child;

**13.01.4.10** and, promote the child's positive attitude towards oral/ dental health.

1. **<u>Routine</u> use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**

2. **Dentists should not restrain children without formal training at a dental school or approved residency program.**

3. **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**

4. **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

## 13.02 Criteria for Dental Extractions

Dental adheres to the following policy for evaluating removal of teeth in order to maintain consistency throughout its dental networks.

Documentation needed for authorization procedure:

• Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth

• Tooth specific narrative demonstrating medical necessity

• A decision regarding benefits is made on the basis of the documentation provided.

• Treatment rendered without necessary pre-authorization is subject to retrospective review.

• Codes:

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

**Criteria:**

• The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.

• The removal of primary teeth whose exfoliation is imminent is not a covered benefit.

• In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.

• Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.

• Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.

• The extraction of primary or permanent teeth does not require authorization unless:

• Teeth are impacted wisdom teeth

• Residual roots requiring surgical removal

• Surgical extraction of erupted teeth.

• Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

**Documentation needed for authorization procedure:**

• Diagnostic quality periapical and/or panoramic radiographs

• Radiographs must be mounted, contain the patient's name and the date the radiographs were taken, not the date of submission

• Duplicate radiographs must be labeled Right (R) and Left (L), include the patient's name and the date the radiograph(s) were taken, not the date of submission.

• Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity that is tooth specific.

**Authorization for extraction of impacted third molars:**

• Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, D7240, and D7241. Benefit review decisions for authorization of the extraction of impacted third molar teeth are tooth specific.

• The prophylactic removal of disease-free third molars are not covered.

• Impacted third molars that do not show pathology will not qualify for an authorization for extraction.

• Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.

• Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.

• Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.

**Reference: American Association of Oral Maxillofacial Surgeons and American Dental Association**

## 13.03 Criteria for Cast Crowns

**Documentation needed for authorization of procedure:**

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

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

**Criteria:**

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

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

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

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

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

- Request should include a dated post-endodontic radiograph.

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

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

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

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

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

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

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.

- Tooth has advanced periodontal disease.

- Tooth is a primary tooth.

- Crowns are being planned to alter vertical dimension.

## 13.04 Criteria for Periodontal Treatment

**Documentation needed for authorization of procedure:**

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

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

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

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

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

**Criteria**

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
    1) Radiographic evidence of root surface calculus.
    2) Radiographic evidence of noticeable loss of bone support.

## 13.05 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

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

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

**Criteria**

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

Root canal therapy must meet the following criteria:

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

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

Authorizations for Root Canal therapy will not meet criteria if:

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

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

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

• Tooth does not demonstrate 50% bone support.

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

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

Other Considerations

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

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

### 13.06 Criteria for Stainless Steel Crowns

Although authorization for Stainless Steel Crowns is not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre-operatively or post-operatively and include the following:

• Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.

• Copy of patient's dental record with complete caries charting and dental anomalies

• Copy of detailed treatment plan.
Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

**Criteria**

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

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

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

• Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.

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

• Primary teeth that have had a pulpotomy or pulpectomy performed.
Note: DentaQuest may require a second opinion for requests of more than 4 stainless steel crowns per patient.

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

• Claim should include a dated post-endodontic radiograph.

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

• The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

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

• The permanent tooth must be at least 50% supported in bone.

• Stainless steel crowns on permanent teeth are expected to last five years.

Criteria for treatment using stainless steel crowns will not be met if:

• A lesser means of restoration is possible.

• Tooth has subosseous and/or furcation caries.

• Tooth has advanced periodontal disease.

• Member is age 6 or older and tooth is a primary tooth with exfoliation imminent.

• Crowns are being planned to alter vertical dimension.

• Tooth has no apparent pathologic destruction due to caries or trauma.

**13.07 Criteria for Removable Prosthodontics (Full and Partial Dentures)**

Documentation needed for authorization of procedure:

• Treatment plan.

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

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

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

**Criteria**

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 prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

• Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.

• As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

• In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

• The replacement teeth should be anatomically full-sized teeth.

Authorizations for Removable prosthesis will not meet criteria:

• If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.

• If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

• If there are untreated cavities or active periodontal disease in the abutment teeth.

• If abutment teeth are less than 50% supported in bone.

• If the recipient cannot accommodate and properly maintain the prosthesis (i.e., Gag reflex, potential for swallowing the prosthesis, severely handicapped) If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

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

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

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

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

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

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

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

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

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

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

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

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

## 13.08 Criteria for Fixed Prosthodontics

**Documentation needed for authorization of procedure:**

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

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

• The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.

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

• Fixed Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.

Authorizations for prosthesis do not meet criteria:

• If appropriate documentation is not received documenting physical or neurological disorders precluding the placement of a removable prosthesis.

• If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

• If abutment teeth are less than 50% supported in bone.

• If there are untreated cavities or active periodontal disease in the abutment teeth.

## 13.09 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

• The tooth has less than 50% bone support.

• The tooth has subosseous and/or furcation caries.

• The tooth is a primary tooth with exfoliation imminent.

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

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

## 13.10 Criteria for Orthodontics

**Limited Orthodontics:**

Covered once per lifetime. Panorex and photographs should be submitted with claim.

**13.10.1** Claims for Limited Orthodontics must be submitted electronically via the Provider Web Portal.

**13.10.2** Only submit a claim for limited orthodontics if the following criteria is met.

- Cross bite of first molar with midline deviation.
- Anterior cross bite associated with clinically apparent severe gingival inflammation or gingival recession or severe enamel wear.
- Impaction causing direct damage to the root of permanent tooth.

**13.10.3** Limited Orthodontic treatment of transitional dentition is orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. This may require brackets or bands on one arch in addition to other modalities. Note: Upper and lower braces exceed the scope of Limited Orthodontics and should be submitted under comprehensive if the member meets the criteria.

**13.10.4** DentaQuest will reimburse the provider for the orthodontic records required for submission. If the provider does not normally charge members for these services, they will not be able to submit these fees for reimbursement. Providers should bill D0150 and panorex code (D0330) if reimbursement is required.

**13.10.5** Reimbursement is considered payment in full for interceptive and comprehensive orthodontics and is based on a pre-determined rate. Payment for interceptive orthodontics includes the following:

- Periodic examinations
- Emergency examinations
- Cost for appliances
- Application and removal of appliance
- Retention

**Comprehensive Orthodontics:**

Covered once per lifetime. Comprehensive orthodontics is a covered dental service for Medicaid and DHCP (Delaware Healthy Children Program) eligible individuals who have been diagnosed with a “handicapping” malocclusion.

Prior authorization is required for any comprehensive orthodontic case that meets the criteria listed below.

- Delaware Special Dental Orthodontic Form: Cases that qualify by exception must also be scored. All items on the form must be fully completed or the case will be denied.
- Treatment plan that must include:
  - Cost of treatment
  - Treatment plan
- Photographs
- Panoramic radiograph
- Cephalometric radiograph
- Digital models
- Orthognathic surgery cases: The member must be evaluated by an oral surgeon prior to submission for comprehensive orthodontics. The oral surgeon’s report must be submitted with the prior authorization for review. If this report is not included, the case will be denied

**Prior to application of braces, the orthodontist must assure that the member has seen a general dentist and is free of all active caries, periodontal disease and maintains good oral hygiene.** Members who have poor oral hygiene, active caries, or have not been to a dentist for their six-month checkup will be denied orthodontic treatment until such time as their condition changes: See the Delaware Special Dental Orthodontic Evaluation Form and guidance when scoring. No treatment should begin without an approval from DentaQuest.

Only submit a prior authorization to DentaQuest for comprehensive orthodontics when the following criterion is met.

- Permanent dentition only. Primary and transitional dentition cases will not be reviewed.
- A score of 26 or above on the Delaware Special Dental Orthodontic Evaluation Form.
- When a score of 26 has not been reached but one of the 5 exceptions can be clearly demonstrated.
- When an impacted permanent tooth has caused visible damage to the root of another permanent tooth. (Must be included in the report as well as demonstrate existing damage to root of tooth.)
- When a child has been approved for orthodontic treatment by another state Medicaid program and has been receiving active and consistent treatment.

**Billing and Payment for Comprehensive Orthodontics:**

Providers will be paid an initial rate for banding, D8090, and a maximum of 24 periodic visits, D8670. Periodic visits are only to be billed once a month and cannot be billed if the patient has not been receiving treatment. Payment for comprehensive orthodontics includes the following:

- Cost of appliances, (brackets, headgear, bite plane, etc.)
- Periodic visits, emergency visits
- Radiographs, photos, reports and final records
- Application, removal and retention
- All incidentals, (spacers, elastics, chains, arch wires)

## 13.11 Criteria for Early and Periodoic Screening, Diagnostic and Treatment (EPSDT)

In compliance with the State of Delaware’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service guidelines, the DMAP endorses the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule. Refer to AAPD.org for the AAPD Periodicity Schedule for recommended guidance pertaining to pediatric oral health assessments, screenings, counseling, and preventative services for children under twenty-one (21) years of age.

## 14.00 Cultural Competency Program

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as healthcare services. Services to Members are delivered in a manner sensitive to the Member's cultural background and his/her religious beliefs, values, and traditions. It is the policy of DentaQuest to provide Medicare, Medicaid, Commercial and DentaQuest employee information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds or physical or mental disabilities issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its Members and DentaQuest employees and report appropriate occurrences to the Complaint and Grievance Department or Human Resources Department.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of services, which acknowledges and incorporates the importance of culture, language, and the values and traditions of Members.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of services, which acknowledges and incorporates the importance of culture, language, and the values and traditions of all DentaQuest's employees.

DentaQuest supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet Members cultural and linguistic needs.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Customer Service Department or via e- mail at **denelig.benfits@dentaquest.com**.

# APPENDIX A

## Attachments

### General Definitions

The following definitions apply to this Office Reference Manual:

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

- an employer, directly or on behalf of AmeriHealth Caritas Delaware as agreed upon between an employer or Plan and DentaQuest (a “Commercial Contract”);
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Delaware or its regulatory agencies or Plan and DentaQuest (a “Medicaid Contract”).

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

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

C. “DentaQuest” shall refer to DentaQuest, LLC.

D. "DentaQuest Service Area" shall be defined by the State of Delaware.

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

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

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

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

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

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

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

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

**Additional Resources**

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

- ADA Dental Claim Form
- Instructions for Dental Claim Form
- Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling
- 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
- HIPAA Companion Guide

**You can also find the forms within this manual.**

# ADA American Dental Association® Dental Claim Form

## HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

## DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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

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

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

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

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

11a. Other Payer ID

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

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

| 13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan) |
|---|---|---|
| 16. Plan/Group Number | 17. Employer Name | |

## PATIENT INFORMATION

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

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

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

## RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)

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

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

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

31a. Other Fee(s)

32. Total Fee

35. Remarks

## AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

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

## ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)

| 38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) |
|---|---|
| | 39a. Date Last SRP |
| 40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY) |
| 42. Months of Treatment / 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY) |
| 45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident | |
| 46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State |

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

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

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

## 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 #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

## COORDINATION OF BENEFITS (COB)

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

## DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

## PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

## PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code | Code |
|---|---|
| **Dentist**<br>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license. | 122300000X |
| **General Practice** | 1223G0001X |
| **Dental Specialty** (see following list) | Various |
| Dental Public Health | 1223D0001X |
| Endodontics | 1223E0200X |
| Orthodontics | 1223X0400X |
| Pediatric Dentistry | 1223P0221X |
| Periodontics | 1223P0300X |
| Prosthodontics | 1223P0700X |
| Oral & Maxillofacial Pathology | 1223P0106X |
| Oral & Maxillofacial Radiology | 1223X0008X |
| Oral & Maxillofacial Surgery | 1223S0112X |

Provider codes listed above are a subset of the full code set that is posted at:
https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

# Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Recommendations on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (*www.aapd.org/policies/*) for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS
**THE BIG AUTHORITY** on little teeth®

| | AGE | | | | |
|---|---|---|---|---|---|
| | 6 TO 12 MONTHS | 12 TO 24 MONTHS | 2 TO 6 YEARS | 6 TO 12 YEARS | 12 YEARS AND OLDER |
| Clinical oral examination [1] | • | • | • | • | • |
| Assess oral growth and development [2] | • | • | • | • | • |
| Caries-risk assessment [3] | • | • | • | • | • |
| Radiographic assessment [4] | • | • | • | • | • |
| Prophylaxis and topical fluoride [3,4] | • | • | • | • | • |
| Fluoride supplementation [5] | • | • | • | • | • |
| Anticipatory guidance/counseling [6] | • | • | • | • | • |
| Oral hygiene counseling [7] | Parent | Parent | Patient/parent | Patient/parent | Patient |
| Dietary counseling [8] | • | • | • | • | • |
| Injury prevention counseling [9] | • | • | • | • | • |
| Counseling for nonnutritive habits [10] | • | • | • | • | • |
| Counseling for speech/language development | • | • | • | | |
| Assessment and treatment of developing malocclusion | | | • | • | • |
| Assessment for pit and fissure sealants [11] | | | • | • | • |
| Substance abuse counseling | | | | • | • |
| Counseling for intraoral/perioral piercing | | | | • | • |
| Assessment and/or removal of third molars | | | | | • |
| Transition to adult dental care | | | | | • |

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

# DELAWARE SPECIAL DENTAL ORTHODONTIC EVALUATION

Derived from California Modification of the Handicapping Labiolingual Deviation {HLD (CalMod)} Index

Name: _____ Medicaid ID # _____
Age: _____ Sex: M / F Provider Name:_____

Comprehensive Orthodontics Billing Provider NPI: _____

FOLLOW GUIDANCE ON FIRST TWO PAGES FOR INFORMATION ON SCORING AND EXCEPTIONS

| | CONDITION | SCORE | EXCEPTION |
|---|---|---|---|
| 1. | **Cleft palate deformity**: score no further if present: Include evaluation from surgeon | | |
| 2. | **Deep impinging overbite:** Soft tissue destruction of the palate must be visible | | |
| 3. | **Crossbite of individual anterior teeth**: When soft tissue destruction is present and visible | | |
| 4. | **Severe traumatic deviations:** Not to be used for impactions/note in comment if impaction qualifies | | |
| 5. | **Overjet greater than 9 mm** with incompetent lips or **reverse overjet greater than 3.5 mm** | | |
| 6. | **Overjet** (mm) | | |
| 7. | **Overbite** (mm) | | |
| 8. | **Mandibular protrusion** (mm) x 5 | | |
| 9. | **Openbite** (mm) x 4 | | |
| 10. | **Ectopic eruption** (# of teeth x 3) See guidance for scoring ectopic and anterior crowding | | |
| 11. | **Anterior crowding** (score 5 when crowding > 3.5 mm per arch) MX MN | | |
| 12. | **Labiolingual spread** (mm) | | |
| 13. | **Posterior unilateral crossbite** (involving molar): score 4 if present | | |
| | **TOTAL SCORE** | | |

Additional Comments_____

_____

Clients Oral Hygiene: Excellent Good Fair Poor

Clients General Dentist Name:_____

Client has no active caries and has received routine dental care. Yes No

Items below to be filled out by DMMA dental orthodontic consultant only.

APPROVED ☐ EXCEPTION ☐ DENIED ☐

COMMENTS:

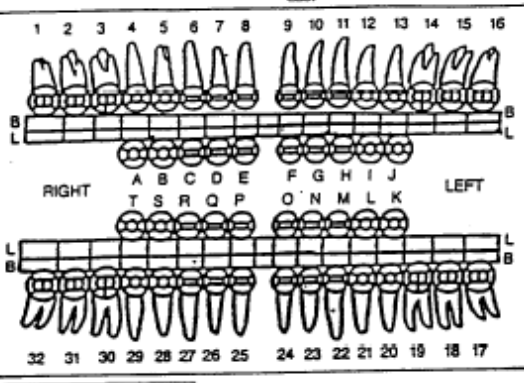
_____

_____

| ALLERGY | PRE MED | MEDICAL ALERT |
|---|---|---|

## INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle




GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION I II III

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

| RADIOGRAPHS | B/P | RDH/DDS |
|---|---|---|

RECOMMENDED TREATMENT PLAN

| TOOTH OR AREA | DIAGNOSIS | PLAN A | PLAN B |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

SIGNATURE OF DENTIST DATE

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

## RECALL EXAMINATION

PATIENT'S NAME_____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

CLINICAL FINDINGS/COMMENTS

| RADIOGRAPHS | B/P | RDH/DDS |
|---|---|---|
| | | |

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

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

COMMENTS:_____

_____

_____

## RECALL EXAMINATION

PATIENT'S NAME_____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

CLINICAL FINDINGS/COMMENTS

| RADIOGRAPHS | B/P | RDH/DDS |
|---|---|---|
| | | |

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

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

COMMENTS:_____

_____

_____

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

## Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

DentaQuest

# AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS

**DISBURSED BY DENTAQUEST, LLC**

## *Indicates Required Field. Please print legibly.

| **Provider Information** | | | |
|---|---|---|---|
| *Provider Name – Complete legal name of corporate entity, practice or individual provider | | Doing Business As (DBA) | |
| **Provider Address** | | | |
| *Street | | *City | |
| *State/Province | | *ZIP Code /Postal Code | |

| **Provider Identifiers Information** | | | |
|---|---|---|---|
| *Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits | | *National Provider Identifier (NPI) Numeric 10 Digits | |

| **Provider Contact Information** | | | |
|---|---|---|---|
| *Provider Contact Name- (Name of contact in provider office authorized to handle EFT issues | | Title | |
| *Telephone Number | | *Email Address | |

| **Financial Institution Information** | | | |
|---|---|---|---|
| *Financial Institution Name | | | |
| **Financial Institution Address** | | | |
| *Street | | *City | |
| *State/Province | | *Zip Code/Postal Code | |
| Financial Institution Telephone Number | | | |
| *Financial Institution Routing Number (Numeric 9 Digits) | | *Type of Account at Financial Institution (e.g., Checking, Saving) | |
| *Provider's Account Number with Financial Institution | | *Account Number Linkage to Provider Identifier – Select One | Provider TIN<br><br>Provider NPI |

| **Submission Information** | | | |
|---|---|---|---|
| ***Reason for Submission** Select One | **New Enrollment** ☐ | **Change Enrollment** ☐ | **Cancel Enrollment** ☐ |
| **Include with Enrollment Submission** | Voided Check<br>A voided check is attached to provide confirmation of Identification/Account Numbers | | |

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

This authorization will remain in effect until revoked by me in writing. I agree **DentaQuest, LLC** 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 **DentaQuest, LLC's** treatment of each such credit entry, and the 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, **DentaQuest, LLC** shall be under no liability whatsoever.

Submission Date

Authorized Signature

Requested EFT Start/Change/Cancel Date

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

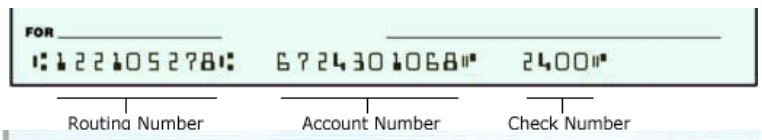
**APPENDIX**
Additional Information to assist with completion of this EFT/ACH Enrollment Form and the EFT/ACH banking process.

## Please note the following *IMPORTANT* information:

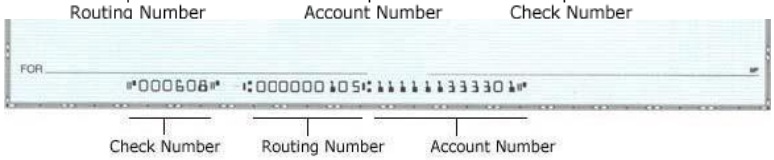
- We are required to inform you that you MUST contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
- **You MUST attach a voided check from your account.**

---

**ACCOUNT HOLDER INFORMATION:**




**Personal Checking Example**




**Business Checking Example**

**Questions?**
You may send your completed form, as well as any questions regarding the status of your EFT enrollment, to the fax number or email address provided below:

Fax: (262)241-4077
Email: StandardUpdates@dentaquest.com

# 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.

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

**For Women Only:**

Are you pregnant? □ Yes □ No

If yes, what month? _____

Are you nursing? □ Yes □ No

Are you taking birth control pills? □ Yes □ No

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

Patient Signature:_____Date: _____

Dentist's Signature:_____Date: _____

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

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

DentaQuest

# 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***

**Change Effective Date *(Required)*:**

*Provider Last Name | *Provider First Name

*Individual National Provider Identifier (NPI) #

Date of Birth | Social Security # | Gender

*Specialty | *Personal E-Mail

**Requestor Information**

*Requestor Name | *Title

*Requestor Contact Information *(Phone or E-mail)*

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

- ☐ 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***

New Last Name | New First Name

New Middle Name | New Suffix

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

**Section 4: License Change**

New Dental License Number | State

New DEA License Number | State

New State Drug License Number | State

New Medicaid License Number | State

Other License Name

Other License Number | State

**Section 5: Credentialing Correspondence Change**

Credentialing Contact Name

Correspondence Address

City | State | Zip Code

Telephone | Fax

Credentialing E-Mail

## Provider Update Form - Provider Operations

**Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.**

☐ Add ☐ Term ☐ Update

Tax ID Number | Medicaid ID (if applicable)

Location Name

Location Address

City | State | Zip Code

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone | Fax

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail

Office Hours: Monday - | Tuesday -

Wednesday - | Thursday -

Friday - | Saturday -

Sunday - | Ages Minimum | Ages Maximum

☐ Primary Location ☐ Handicapped Accessible

Office Languages

**Section 7: Business - (Tax ID) Add/ Term/ Update - *Updated Contract, W9 and Disclosure of Ownership required for all Adds and Updates - W9 and Disclosure of Ownership Attached***

☐ Add ☐ Term ☐ Update

Old/ Current Tax ID Number | New Tax ID Number

Business Name

Business Address

City | State | Zip Code

Telephone | Fax

Office E-Mail

Group NPI

Please Note: DentaQuest requires a Group NPI for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?
If yes, please provide a date of when all claims will be submitted by: _____ ☐ Yes ☐ No

**Section 8: EFT/ Payment**

Tax ID Number

Payment Address

City | State | Zip Code

☐ Add EFT ☐ Cancel EFT ☐ Change EFT

Please Note: The DentaQuest EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached)

## Provider Update Form - Provider Operations

**Section 9: Termination Request**

☐ Term Provider at Location Listed Below | Tax ID Number

Please attach document with any additional locations to be termed.

☐ Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐ Term Business | Tax ID Number

Please attach a list of providers and locations that need to be terminated.

Term Reason/ Comments

Location Name

Location Address

City | State | Zip Code

**Section 10: Type of Update - Check all that Apply - *Complete for ALL Requests - Internal Use ONLY***

- ☐ Product(s) Add/ Update/ Term- Complete Sections 1, 10 and Notes
- ☐ Claims Issue(s) - Complete Sections 1, 10 and Notes
- ☐ Dental Home - Complete Sections 1, 10 and Notes
- ☐ Fee Schedule Add - Complete Sections 1, 10 and Notes
- ☐ Fee Schedule Change - Complete Sections 1, 10 and Notes
- ☐ Provider Rule Add - Complete Sections 1, 10 and Notes
- ☐ Provider Rule Change - Complete Sections 1, 10 and Notes

**Notes**

# Request for Transfer of Records

I,_____, hereby request and give my permission to Dr._____to provide Dr._____any and all information regarding past dental care for_____.

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

Please have these records sent to:

_____

_____

_____

Signed:_____Date:_____
(Patient)

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

Address: _____

Address: _____

Phone: _____

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

Member Name: _____

Member ID: _____

Treating Provider Name: _____

Service Location Name and Address: _____

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

**Non-Covered Services**

| Code | Cost | Description | Reason service is not covered |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

_____ _____

Member Signature Date

_____

*Witness Signature*

# APPENDIX B

**Covered Benefits (See Exhibits)**

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members enrolled in the program. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at 1.855.343.7403**.

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

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

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

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

**American Dental**
**Association 211 E. Chicago**
**Ave. Chicago, IL 60611**
**1.800.947.4746**

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

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

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

## DentaQuest Prior Authorization & Pre-Payment Process

### IMPORTANT

**For procedures where "Prior Authorization Required" or "Pre-Payment Review Required" fields indicate "Yes".**

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

**When documentation is requested prior to treatment:**

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

**When documentation is requested "with claim:"**

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

### PLEASE NOTE

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

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

**Delaware Emergency Dental Benefit**

The Adult dental benefit is capped at $1,000 per calendar year per individual. Additional services may be accessed through the emergency benefit once the $1,000 annual benefit limit is reached.

Delaware Medicaid individuals (over the age of 21) are eligible to receive an additional $1,500 per year beyond the $1,000 annual benefit limit for dental care treatment that may be authorized on an emergency basis through a review process as provided by the Division of Medicaid and Medical Assistance. In order to access the additional funds, an individual's $1,000 annual benefit must be exhausted. If an individual experiences a dental emergency and has funds available under the $1,000 annual benefit these must be used first prior to accessing the additional $1,500 in funds.

DHSS defines emergency basis as:

a) An unforeseen or sudden occurrence demanding immediate remedy or action, without which a reasonable licensed dental professional would predict a serious health risk or rapid decline in oral health.

b) When an individual's dental care needs exceed the $1,000 per year dental benefit limit, and postponement of treatment until the next benefit year would result in tooth loss or exacerbation of an existing medical condition.

To access the additional $1,500 emergency/extended per year dental benefit, the enrolled dental provider must:

- Except in cases of an emergency as defined in a. above, submit for prior authorization, a comprehensive treatment plan which anticipates the preventive, therapeutic and restorative needs for the recipient prior to rendering services, including:
    - Complete record of existing restorations, conditions and diagnoses
    - Comprehensive periodontal assessment record
    - Diagnostic full mouth series of x-rays
    - Intra- and extra-oral images that support the diagnosis and treatment plan

- In situations where a recipient presents with an unforeseen or sudden occurrence, provide diagnostic-quality pre- and post-operative radiographs and images of the affected area along with a detailed narrative supporting the provider's rationale for immediate services.

- Only covered procedures and/or services that meet clinical practice guidelines and that are included in the DMMA fee schedule will be approved.

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

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

| Diagnostic | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D0120 | periodic oral evaluation - established patient | 21 and older | | No | No | One of (D0120) per 6 Month(s) Per patient. | |
| D0140 | limited oral evaluation-problem focused | 21 and older | | No | No | | |
| D0150 | comprehensive oral evaluation - new or established patient | 21 and older | | No | No | One of (D0150) per 2 Year(s) Per patient. | |
| D0160 | detailed and extensive oral eval-problem focused, by report | 21 and older | | No | No | | |
| D0170 | re-evaluation, limited problem focused | 21 and older | | No | No | Narrative of medical necessity. | narrative of medical necessity |
| D0180 | comprehensive periodontal evaluation - new or established patient | 21 and older | | No | No | One of (D0180) per 2 Year(s) Per patient. | |
| D0210 | intraoral - comprehensive series of radiographic images | 21 and older | | No | No | One of (D0210, D0330) per 3 Year(s) Per patient. | |
| D0220 | intraoral - periapical first radiographic image | 21 and older | | No | No | One of (D0220) per 1 Year(s) Per patient. | |
| D0230 | intraoral - periapical each additional radiographic image | 21 and older | | No | No | Five of (D0230) per 1 Year(s) Per patient. | |
| D0272 | bitewings - two radiographic images | 21 and older | | No | No | One of (D0272) per 6 Month(s) Per patient. | |

## Exhibit A Benefits Covered for
## Diamond State Health Plan / Diamond State Health Plan-Plus (LTSS) / Diamond State Health Plan-Plus

| Diagnostic | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D0274 | bitewings - four radiographic images | 21 and older | | No | No | One of (D0274) per 6 Month(s) Per patient. | |
| D0330 | panoramic radiographic image | 21 and older | | No | No | One of (D0210, D0330) per 3 Year(s) Per patient. Either a D0210 or D0330. (only exception is diagnosis of new condition (i.e. traumatic injury)). Minimum of 14 images. Must be billed after approval or denial of implant pre-authorization request. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

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

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

| Preventative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D1110 | prophylaxis - adult | 21 and older | | No | No | One of (D1110) per 6 Month(s) Per patient. | |
| D1206 | topical application of fluoride varnish | 21 and older | | No | No | Two of (D1206, D1208) per 1 Year(s) Per patient. One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1208 | topical application of fluoride - excluding varnish | 21 and older | | No | No | Two of (D1206, D1208) per 1 Year(s) Per patient. One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1354 | application of caries arresting medicament- per tooth | 21 and older | Teeth 1 - 32 | No | No | One of (D1354) per 6 Month(s) Per patient per tooth. | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

DentaQuest recognizes that emergency situations may arise. Treatment under these conditions is to alleviate member of a major source of pain, and not meant to be comprehensive treatment. In these situations, a Prior Authorization is not required. Participating Providers should submit the Adult Emergency Services as a Claim. The Claim should include a narrative supporting the Emergency Services rendered, along with supporting labeled x-rays and chart notes. The narrative must include the tooth number and reason services being rendered qualify as an emergency. Indication of the level of patient pain (unable to eat/sleep), swelling, bleeding and/or any kind of trauma must be documented in the narrative. It is essential that the Participating Provider understand that claims sent without this "documentation" to support the emergency treatment rendered, will be denied for payment. Although DentaQuest does permit the submission of a Prior Authorization, it is not necessary and we encourage treating the emergency the day the patient presents with severe pain and/or infection.
Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, per per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration.
Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery date. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
Reimbursement includes local anesthesia

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

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2140 | Amalgam - one surface, primary or permanent | 21 and older | Teeth 1 - 32 | No | No | One of (D2140) per 2 Year(s) Per patient per tooth, per surface. | |
| D2150 | Amalgam - two surfaces, primary or permanent | 21 and older | Teeth 1 - 32 | No | No | One of (D2150) per 2 Year(s) Per patient per tooth, per surface. | |
| D2160 | amalgam - three surfaces, primary or permanent | 21 and older | Teeth 1 - 32 | No | No | One of (D2160) per 2 Year(s) Per patient per tooth, per surface. | |
| D2161 | amalgam - four or more surfaces, primary or permanent | 21 and older | Teeth 1 - 32 | No | No | One of (D2161) per 2 Year(s) Per patient per tooth, per surface. | |
| D2330 | resin-based composite - one surface, anterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2330) per 2 Year(s) Per patient per tooth, per surface. | |
| D2331 | resin-based composite - two surfaces, anterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2331) per 2 Year(s) Per patient per tooth, per surface. | |
| D2332 | resin-based composite - three surfaces, anterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2332) per 2 Year(s) Per patient per tooth, per surface. | |
| D2335 | resin-based composite - four or more surfaces (anterior) | 21 and older | Teeth 1 - 32 | No | No | One of (D2335) per 2 Year(s) Per patient per tooth. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

## Exhibit A Benefits Covered for
## Diamond State Health Plan / Diamond State Health Plan-Plus (LTSS) / Diamond State Health Plan-Plus

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2390 | resin-based composite crown, anterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2390) per 5 Year(s) Per patient per tooth, per surface. | |
| D2391 | resin-based composite - one surface, posterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2391) per 2 Year(s) Per patient per tooth, per surface. | |
| D2392 | resin-based composite - two surfaces, posterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2392) per 2 Year(s) Per patient per tooth, per surface. | |
| D2393 | resin-based composite - three surfaces, posterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2393) per 2 Year(s) Per patient per tooth, per surface. | |
| D2394 | resin-based composite - four or more surfaces, posterior | 21 and older | Teeth 1 - 32 | No | No | One of (D2394) per 2 Year(s) Per patient per tooth, per surface. | |
| D2920 | re-cement or re-bond crown | 21 and older | Teeth 1 - 32 | No | No | One of (D2920) per 2 Year(s) Per patient per tooth, per surface. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

Claims for preventive dental procedure codes D1110 & D1208 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes. Covered services may require a prior-authorization or be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form. The use of irrigation services/materials in conjunction with other periodontal services is included in the periodontal service provided. It cannot be billed separately nor can the patient be billed for irrigation services/materials. Reimbursement includes local anesthetic.

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

| Periodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D4341 | periodontal scaling and root planing - four or more teeth per quadrant | 21 and older | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | | Full mouth xrays & perio charting |
| D4342 | periodontal scaling and root planing - one to three teeth per quadrant | 21 and older | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | | Full mouth xrays & perio charting |
| D4355 | full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | 21 and older | | No | No | One of (D4355) per 3 Year(s) Per patient. | Full mouth xrays & perio charting |
| D4910 | periodontal maintenance procedures | 21 and older | | No | No | One of (D1110, D4910) per 3 Month(s) Per patient. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery date.
If partial dentures are recommended, they must be deemed essential for function. As a standard, it may be considered that six posterior teeth in occlusion (three maxillary and three mandibular teeth in functional contact with each other) will be considered adequate for functional purposes.
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.

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

| Prosthodontics, removable | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5511 | repair broken complete denture base, mandibular | 21 and older | | No | No | | |
| D5512 | repair broken complete denture base, maxillary | 21 and older | | No | No | | |
| D5520 | replace missing or broken teeth - complete denture - per tooth | 21 and older | Teeth 1 - 32 | No | No | | |
| D5630 | repair or replace broken retentive/clasping materials per tooth | 21 and older | Teeth 1 - 32 | No | No | | |
| D5640 | replace missing or broken teeth – partial denture – per tooth | 21 and older | Teeth 1 - 32 | No | No | | |
| D5650 | add tooth to existing partial denture – per tooth | 21 and older | Teeth 1 - 32 | No | No | | |
| D5660 | add clasp to existing partial denture | 21 and older | Teeth 1 - 32 | No | No | | |
| D5750 | reline complete maxillary denture (laboratory) | 21 and older | | No | No | One of (D5750) per 2 Year(s) Per patient. | |
| D5751 | reline complete mandibular denture (laboratory) | 21 and older | | No | No | One of (D5751) per 2 Year(s) Per patient. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

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

| Prosthodontics, fixed | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D6930 | re-cement or re-bond fixed partial denture | 21 and older | | No | No | | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection.
The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

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

| Oral and Maxillofacial Surgery | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 21 and older | Teeth 1 - 32 | No | No | One of (D7140, D7210, D7220) per 1 Lifetime Per patient per tooth. | |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 21 and older | Teeth 1 - 32 | No | No | One of (D7140, D7210, D7220) per 1 Lifetime Per patient per tooth. | |
| D7220 | removal of impacted tooth-soft tissue | 21 and older | Teeth 1 - 32 | No | No | One of (D7140, D7210, D7220) per 1 Lifetime Per patient per tooth. | |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | 21 and older | Teeth 1 - 32 | No | No | | |
| D7510 | incision and drainage of abscess - intraoral soft tissue | 21 and older | Teeth 1 - 32 | No | No | | |
| D7520 | incision and drainage of abscess - extraoral soft tissue | 21 and older | | No | No | | |
| D7521 | incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | 21 and older | | No | No | | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

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

| Adjunctive General Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9110 | palliative treatment of dental pain - per visit | 21 and older | | No | No | Two of (D9110) per 1 Year(s) Per patient. | narrative of medical necessity |
| D9222 | deep sedation/general anesthesia first 15 minutes | 21 and older | | No | Yes | | narrative of medical necessity |
| D9223 | deep sedation/general anesthesia - each subsequent 15 minute increment | 21 and older | | No | Yes | | narrative of medical necessity |
| D9230 | inhalation of nitrous oxide/analgesia, anxiolysis | 21 and older | | No | Yes | | narrative of medical necessity |
| D9239 | intravenous moderate (conscious) sedation/analgesia- first 15 minutes | 21 and older | | No | Yes | | narrative of medical necessity |
| D9243 | intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | 21 and older | | No | Yes | | narrative of medical necessity |
| D9248 | non-intravenous moderate sedation | 21 and older | | No | Yes | | narrative of medical necessity |
| D9995 | teledentistry – synchronous; real-time encounter | 21 and older | | No | No | | |
| D9996 | teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review | 21 and older | | No | No | Must be billed with D0140. | |

AmeriHealth Caritas Delaware - DSHP (Medicaid 21 and Over)

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.
Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration. If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.
A comprehensive examination (D0150) is performed on a new or established patient. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc. A periodic examination (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.
Any dental service that is deemed medically necessary by the dentist should be submitted for prior authorization to be covered. It is strongly recommended that the Dental Periodicity Schedule be used as a guide for the provision of services with the understanding that services may be provided more frequently as medically indicated.
Out-of-office services: Providers who render preventive exams in an out-of-office setting must check the 'Other' box (Box 38) on the ADA form or, if filing electronically, put code 03 for school or 99 for other , as appropriate. Providers who render comprehensive services in an out-of-office setting must check the 'Provider's Office' or 'ECF' (Extended Care Facility) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for extended care facility or 99 for other, as appropriate. Dental Providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleanings, and fluoride treatment. Each provider must provide any follow-up sealants in addition to the exam, cleaning and fluoride treatment when needed.

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

| Diagnostic | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D0120 | periodic oral evaluation - established patient | 0-20 | | No | No | One of (D0120, D0145, D0150) per 6 Month(s) Per patient. Must include caries risk assessment code. | |
| D0140 | limited oral evaluation-problem focused | 0-20 | | No | No | Denied when submitted on the same DOS as D0120, D0145, D0150, D0160, D0170, D0180) | |
| D0145 | oral evaluation for a patient under three years of age and counseling with primary caregiver | 0-2 | | No | No | One of (D0120, D0145, D0150) per 6 Month(s) Per patient. Must include caries risk assessment code. | |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Diagnostic | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D0150 | comprehensive oral evaluation - new or established patient | 0-20 | | No | No | One of (D0150) per 24 Month(s) Per Provider. Must include caries risk assessment code. | |
| D0160 | detailed and extensive oral eval-problem focused, by report | 0-20 | | No | No | Must include caries risk assessment code. | |
| D0170 | re-evaluation, limited problem focused | 0-20 | | Yes | No | Narrative of medical necessity. | narrative of medical necessity |
| D0180 | comprehensive periodontal evaluation - new or established patient | 14-20 | | No | No | Allowed for Periodontist and/or General Dentist only. | |
| D0190 | Screening of a patient | 0-20 | | No | No | Code limited to Division of Public Health (DPH) contracted providers only | |
| D0191 | Assessment of a patient | 0-20 | | No | No | Code limited to Division of Public Health (DPH) contracted providers only | |
| D0210 | intraoral - comprehensive series of radiographic images | 7 - 20 | | No | No | One of (D0210, D0330) per 3 Year(s) Per patient. Request patient x-rays if provided by another provider within past 3 years. | |
| D0220 | intraoral - periapical first radiographic image | 0-20 | | No | No | Fifteen of (D0220) per 1 Year(s) Per patient. | |
| D0230 | intraoral - periapical each additional radiographic image | 0-20 | | No | No | Five of (D0230) per 1 Year(s) Per patient. | |
| D0240 | intraoral - occlusal radiographic image | 0-20 | | No | No | Two of (D0240) per 1 Day(s) Per patient. | |
| D0270 | bitewing - single radiographic image | 0-20 | | No | No | One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient. | |
| D0272 | bitewings - two radiographic images | 0-20 | | No | No | One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient. | |
| D0273 | bitewings - three radiographic images | 0-20 | | No | No | One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient. | |

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Diagnostic | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D0274 | bitewings - four radiographic images | 0-20 | | No | No | One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient. | |
| D0277 | vertical bitewings - 7 to 8 films | 7-20 | | No | No | 7-8 x-rays; Cannot bill with D0210 or other bitewing code | |
| D0322 | tomographic survey | 8-20 | | No | No | | |
| D0330 | panoramic radiographic image | 5-20 | | No | No | One of (D0210, D0330) per 3 Year(s) Per patient. Request patient x-rays if provided by another provider within past 3 years. May be billed with D0272 or D0274. | |
| D0350 | 2D oral/facial photographic image obtained intra-orally or extra-orally | 3-20 | | No | No | One of (D0350) per 6 Month(s) Per patient. | |
| D0601 | Caries risk assessment and documentation, with a finding of low risk | 0-20 | | No | No | Caries code must be billed on same claim with exam | |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk | 0-20 | | No | No | Caries code must be billed on same claim with exam. AAPD Table 2, 3 completed must be retained in chart. | |
| D0603 | Caries risk assessment and documentation, with a finding of high risk | 0-20 | | No | No | Caries code must be billed on same claim with exam | |
| D0999 | unspecified diagnostic procedure, by report | 0-20 | | Yes | Yes | | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

**Exhibit B Benefits Covered for**
**AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)**

Preventive services include routine and prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy for Participants age 0 through 20. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.
Routine prophylaxis is covered for Participants age 0 through 20, once every 6 months in an office or school. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details. Fluoride treatment (D1206 or D1208) is allowed once every 6 months in an office or school setting for Participants age 3 through 20.For ages 0 through 2, three fluoride varnish treatments (D1206) are allowed per patient per 12 months in an office setting. Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations. Space maintainers are a covered service for Participants age 1 through 20 when determined by the entist to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent. A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit. Place of service must be indicated on all claims. Out-of-office services: Providers who render preventive services in an out-of-office setting must check the 'Other' box (Box 38) on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the 'Provider's Office' or 'ECF' (Extended Care Facilities) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate. Dental providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning and fluoride treatment. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed. Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

| Preventative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D1110 | prophylaxis - adult | 13-20 | | No | No | One of (D1110, D1120) per 6 Month(s) Per patient. | |
| D1120 | prophylaxis - child | 1-12 | | No | No | One of (D1110, D1120) per 6 Month(s) Per patient. | |
| D1206 | topical application of fluoride varnish | 0-20 | | No | No | Two of (D1206, D1208) per 1 Year(s) Per patient. One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1208 | topical application of fluoride - excluding varnish | 0-20 | | No | No | Two of (D1206, D1208) per 1 Year(s) Per patient. One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1351 | sealant - per tooth | 2-6 | Teeth A, B, I - L, S, T | No | No | Eight of (D1351) per 12 Month(s) Per patient. One of (D1351) per 60 Month(s) Per patient per tooth. | |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Preventative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D1351 | sealant - per tooth | 5-15 | Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31 | No | No | Eight of (D1351) per 12 Month(s) Per patient. One of (D1351) per 60 Month(s) Per patient per tooth. | |
| D1351 | sealant - per tooth | 5-16 | Teeth 1, 16, 17, 32 | Yes | No | Eight of (D1351) per 12 Month(s) Per patient. One of (D1351) per 60 Month(s) Per patient per tooth. | |
| D1354 | application of caries arresting medicament- per tooth | 0-20 | Teeth 1 - 32, A - T | No | No | Two of (D1354) per 1 Lifetime Per patient per tooth. Ten of (D1354) per 1 Day(s) Per patient per tooth. | |
| D1510 | space maintainer-fixed, unilateral-per quadrant | 2-9 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | No | See Dental Provider Policy Manual | |
| D1515 | space maintainer - fixed - bilateral | 2-9 | Per Arch (01, 02, LA, UA) | No | No | See Dental Provider Policy Manual | |
| D1516 | space maintainer --fixed--bilateral, maxillary | 2-9 | Per Arch (01, UA) | No | No | | |
| D1517 | space maintainer --fixed--bilateral, mandibular | 2-9 | Per Arch (02, LA) | No | No | | |
| D1551 | re-cement or re-bond bilateral space maintainer- Maxillary | 2-12 | | No | No | | |
| D1552 | re-cement or re-bond bilateral space maintainer- Mandibular | 2-12 | | No | No | | |
| D1553 | re-cement or re-bond unilateral space maintainer- Per Quadrant | 2-12 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | No | | |
| D1556 | Removal of fixed unilateral space maintainer- Per Quadrant | 2-12 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | Yes | No | Only billed when office did not insert appliance | |
| D1557 | Removal of fixed bilateral space maintainer- Maxillary | 2-12 | | Yes | No | Only billed when office did not insert appliance | |
| D1558 | Removal of fixed bilateral space maintainer- Mandibular | 2-12 | | Yes | No | Only billed when office did not insert appliance | |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.
Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date. Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

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

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2140 | Amalgam - one surface, primary or permanent | 1 - 20 | Teeth 1 - 32, A - T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2150 | Amalgam - two surfaces, primary or permanent | 1 - 20 | Teeth 1 - 32, A - T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2160 | amalgam - three surfaces, primary or permanent | 1 - 20 | Teeth 1 - 32, A - T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2161 | amalgam - four or more surfaces, primary or permanent | 1 - 20 | Teeth 1 - 32, A - T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2330 | resin-based composite - one surface, anterior | 1 - 20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface. | |
| D2331 | resin-based composite - two surfaces, anterior | 1 - 20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface. | |
| D2332 | resin-based composite - three surfaces, anterior | 1 - 20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2335 | resin-based composite - four or more surfaces (anterior) | 1 - 20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2390 | resin-based composite crown, anterior | 1 - 20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | No | One of (D2390) per 5 Year(s) Per patient per tooth. | |
| D2391 | resin-based composite - one surface, posterior | 1 - 20 | Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2392 | resin-based composite - two surfaces, posterior | 1 - 20 | Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2393 | resin-based composite - three surfaces, posterior | 1 - 20 | Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2394 | resin-based composite - four or more surfaces, posterior | 1 - 20 | Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T | No | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth. | |
| D2710 | crown - resin-based composite (indirect) | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2740 | crown - porcelain/ceramic | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2751 | crown - porcelain fused to predominantly base metal | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2752 | crown - porcelain fused to noble metal | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2791 | crown - full cast predominantly base metal | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2792 | crown - full cast noble metal | 14-20 | Teeth 1 - 32 | No | Yes | One of (D2710, D2740, D2751, D2752, D2791, D2792) per 60 Month(s) Per patient per tooth. x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2799 | interim crown | 14-20 | Teeth 1 - 32 | No | Yes | x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2910 | re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | 14-20 | Teeth 1 - 32 | No | No | | |
| D2915 | re-cement or re-bond indirectly fabricated or prefabricated post and core | 14-20 | Teeth 1 - 32 | Yes | No | Must include narrative on claim | narrative of medical necessity |

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2920 | re-cement or re-bond crown | 2-20 | Teeth 1 - 32, A - T | No | No | One of (D2920) per 2 Year(s) Per patient per tooth, per surface. | |
| D2929 | Prefabricated porcelain/ceramic crown – primary tooth | 0-20 | Teeth C - H, M - R | No | No | One of (D2929) per 1 Lifetime Per patient per tooth. | |
| D2930 | prefabricated stainless steel crown - primary tooth | 1-20 | Teeth A - C, H - M, R - T | No | No | One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Extraction if more than 1/2 root resorbed | |
| D2931 | prefabricated stainless steel crown-permanent tooth | 6-20 | Teeth 1 - 32 | No | No | One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. | |
| D2932 | prefabricated resin crown | 2-20 | Teeth 1 - 32, A - T | No | No | One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. Extraction if more than 1/2 root resorbed | |
| D2933 | prefabricated stainless steel crown with resin window | 2-20 | Teeth C, H, M, R | No | No | One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. | |
| D2934 | prefabricated esthetic coated stainless steel crown - primary tooth | 0-20 | Teeth C - H, M - R | No | No | One of (D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth. | |
| D2940 | Placement of interim direct restoration. | 1-20 | Teeth 1 - 32, A - T | No | No | Not billable same day as restoration | |
| D2950 | core buildup, including any pins when required | 6-20 | Teeth 1 - 32 | No | No | Not billable with code D2951 or other restorations | |
| D2951 | pin retention - per tooth, in addition to restoration | 6-20 | Teeth 1 - 32 | No | No | | |
| D2952 | cast post and core in addition to crown | 6-20 | Teeth 1 - 32 | Yes | No | Billed only after endo on tooth | |
| D2953 | each additional cast post - same tooth | 6-20 | Teeth 1 - 32 | No | Yes | x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2954 | prefabricated post and core in addition to crown | 6-20 | Teeth 1 - 32 | No | No | | |

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Restorative | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D2955 | post removal (not in conjunction with endodontic therapy) | 6-20 | Teeth 1 - 32 | Yes | No | Narrative of medical necessity. | narrative of medical necessity |
| D2957 | each additional prefabricated post - same tooth | 6-20 | Teeth 1 - 32 | No | Yes | x-ray required less than 1 month old. | pre-operative x-ray(s) |
| D2980 | crown repair, by report | 14-20 | Teeth 1 - 32, A - T | Yes | No | Narrative of medical necessity. | narrative of medical necessity |
| D2999 | unspecified restorative procedure, by report | 1-20 | Teeth 1 - 32, A - T | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.
The following guidelines must be followed when providing endodontic services:
Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.
The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Dental Industry (or ADA) treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.
Root canals and pulpotomies may not be covered in the following situations:
* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

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

| Endodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D3110 | pulp cap - direct (exluding final restoration) | 0-20 | Teeth 1 - 32, A - T | No | No | One of (D3110) per 1 Lifetime Per patient per tooth. | |
| D3120 | pulp cap - indirect (excluding final restoration) | 0-20 | Teeth 1 - 32, A - T | No | No | One of (D3120) per 1 Lifetime Per patient per tooth. | |
| D3220 | therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | 1-10 | Teeth 1 - 32, A - T | No | No | Not billable same day as Endodontic Therapy | |
| D3221 | pulpal debridement, primary and permanent teeth | 6-20 | Teeth 1 - 32, A - T | No | No | Not billable same day as Endodontic Therapy | |
| D3222 | partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | 6-20 | Teeth 1 - 32 | No | No | Not billable same day as Endodontic Therapy | |
| D3230 | pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) | 2-6 | Teeth C - H, M - R | No | No | Not billable same day as Endodontic Therapy | |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

| Endodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D3240 | pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) | 2-9 | Teeth A, B, I - L, S, T | No | No | Not billable same day as Endodontic Therapy | |
| D3310 | endodontic therapy, anterior tooth (excluding final restoration) | 6-20 | Teeth 6 - 11, 22 - 27 | Yes | No | See Dental Provider Policy Manual | narr. of med. necessity, pre-op x-ray(s) |
| D3320 | endodontic therapy, premolar tooth (excluding final restoration) | 8-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | Yes | No | See Dental Provider Policy Manual | narr. of med. necessity, pre-op x-ray(s) |
| D3330 | endodontic therapy, molar tooth (excluding final restoration) | 6-20 | Teeth 1 - 3, 14 - 19, 30 - 32 | Yes | No | See Dental Provider Policy Manual | narr. of med. necessity, pre-op x-ray(s) |
| D3332 | incomplete endodontic therapy; inoperable or fractured tooth | 6-20 | Teeth 1 - 32 | Yes | No | See Dental Provider Policy Manual | narr. of med. necessity, pre-op x-ray(s) |
| D3333 | internal root repair of perforation defects | 6-20 | Teeth 1 - 32 | No | No | Not billable with D9110 or D3220 on same day | |
| D3346 | retreatment of previous root canal therapy-anterior | 8-20 | Teeth 6 - 11, 22 - 27 | No | No | | |
| D3347 | retreatment of previous root canal therapy - premolar | 10-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | No | No | | |
| D3348 | retreatment of previous root canal therapy-molar | 8-20 | Teeth 1 - 3, 14 - 19, 30 - 32 | No | No | | |
| D3351 | apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | 6-16 | Teeth 1 - 32 | No | No | | |
| D3352 | apexification/recalcification - interim medication replacement | 6-16 | Teeth 1 - 32 | No | No | | |
| D3353 | apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | 6-16 | Teeth 1 - 32 | No | No | | |
| D3410 | apicoectomy - anterior | 9-20 | Teeth 6 - 11, 22 - 27 | No | No | | |

| Endodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D3421 | apicoectomy - premolar (first root) | 9-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | No | No | | |
| D3425 | apicoectomy - molar (first root) | 9-20 | Teeth 1 - 3, 14 - 19, 30 - 32 | No | No | | |
| D3426 | apicoectomy (each additional root) | 9-20 | Teeth 1 - 5, 12 - 21, 28 - 32 | No | No | | |
| D3430 | retrograde filling - per root | 9-20 | Teeth 1 - 32 | No | No | | |
| D3999 | unspecified endodontic procedure, by report | 1-20 | Teeth 1 - 32, A - T | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Periodontal scaling and root planning, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.
Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

| Periodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D4210 | gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | 13-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | Narrative of Medical Necessity,Photograph Required | Narrative of medical necessity and photos |
| D4211 | gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 13-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | Narrative of Medical Necessity,Photograph Required | Narrative of medical necessity and photos |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | 13-20 | Teeth 1 - 32, 51 - 82 | No | Yes | Narrative of Medical Necessity,Photograph Required | Narrative of medical necessity and photos |
| D4260 | osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | 15-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4261 | osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | 15-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4263 | bone replacement graft - first site in quadrant | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4264 | bone replacement graft - each additional site in quadrant | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4265 | biological materials to aid in soft and osseous tissue regeneration per site | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4266 | guided tissue regeneration, natural teeth – resorbable barrier, per site | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |

| Periodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D4267 | guided tissue regeneration, natural teeth – non-resorbable barrier, per site | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D4270 | pedicle soft tissue graft procedure | 8-20 | Teeth 1 - 32 | No | Yes | | |
| D4273 | subepithelial connective tissue graft procedure | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4274 | distal or proximal wedge procedure | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4275 | soft tissue allograft | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4276 | combined connective tissue and double pedicle graft | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4322 | splint – intra-coronal; natural teeth or prosthetic crowns | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4323 | splint – extra-coronal; natural teeth or prosthetic crowns | 13-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |
| D4341 | periodontal scaling and root planing - four or more teeth per quadrant | 14-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | Yes | No | One of (D4341) per 24 Month(s) Per patient per quadrant. Two of (D4341) per 1 Day(s) Per patient. Full series of x-rays and periodontal charting; 1/2 mouth per visit. | Full mouth xrays & perio charting |
| D4342 | periodontal scaling and root planing - one to three teeth per quadrant | 14-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | Yes | No | One of (D4342) per 24 Month(s) Per patient per quadrant. Four of (D4342) per 1 Day(s) Per patient. Not to be billed with D4341 | Full mouth xrays & perio charting |
| D4355 | full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | 14-20 | | Yes | No | One of (D4355) per 3 Year(s) Per patient. Cannot be billed with D1110, D4341, D4342, or with an Oral Exam | Full mouth xrays & perio charting |

**Exhibit B Benefits Covered for**
**AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)**

| Periodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D4910 | periodontal maintenance procedures | 14-20 | | No | No | One of (D1110, D4910) per 3 Month(s) Per patient. Must have had D4341 OR D4342; One (1) time in 3 Month(s) and alternate with D1110. | |
| D4920 | unscheduled dressing change (by someone other than treating dentist or their staff) | 14-20 | | Yes | No | Covered when provider removing is in different practice | |
| D4999 | unspecified periodontal procedure, by report | 0-20 | | No | Yes | | |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.
Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. The date of placement must be used as the date of service when submitting for payment of dentures. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.
In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.
Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.
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.
A partial denture that replaces only posterior permanent teeth must include three or more teeth on the denture that are anatomically correct (natural size, shape and color). Partial dentures must include one anterior tooth and/or 3 posterior teeth (including third molars).
Denture benefits for patients with the following medical conditions will not be considered for coverage:
* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

| Prosthodontics, removable | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5110 | complete denture - maxillary | 14-20 | | No | Yes | One of (D5110) per 60 Month(s) Per patient per arch. Not billable within 36 Month(s) of D5211, D5213, D5225 | Full mouth x-rays |
| D5120 | complete denture - mandibular | 14-20 | | No | Yes | One of (D5120) per 60 Month(s) Per patient per arch. Not billable within 36 Month(s) of D5212, D5214, D5226 | Full mouth x-rays |
| D5211 | maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth) | 14-20 | | No | Yes | One of (D5211, D5213, D5225) per 60 Month(s) Per patient per arch. Narrative of Medical Necessity, Xray Required | Full mouth x-rays |

| Prosthodontics, removable | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5212 | mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth) | 14-20 | | No | Yes | One of (D5212, D5214, D5226) per 60 Month(s) Per patient per arch. Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D5213 | maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | 16-20 | | No | Yes | One of (D5211, D5213, D5225) per 60 Month(s) Per patient per arch. Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D5214 | mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | 16-20 | | No | Yes | One of (D5212, D5214, D5226) per 60 Month(s) Per patient per arch. Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D5225 | maxillary partial denture-flexible base | 16-20 | | No | Yes | One of (D5211, D5213, D5225) per 60 Month(s) Per patient per tooth. Narrative of Medical Necessity, Xray Required. Includes retentive / clasping material, rests, and teeth. | Full mouth x-rays |
| D5226 | mandibular partial denture-flexible base | 16-20 | | No | Yes | One of (D5212, D5214, D5226) per 60 Month(s) Per patient per tooth. Narrative of Medical Necessity, Xray Required. Includes retentive / clasping material, rests, and teeth. | Full mouth x-rays |
| D5410 | adjust complete denture - maxillary | 14-20 | | Yes | No | One of (D5410) per 12 Month(s) Per patient. Not billable within 6 months of delivery of, interim, partial or complete denture. | Full mouth x-rays |
| D5411 | adjust complete denture - mandibular | 14-20 | | Yes | No | One of (D5411) per 12 Month(s) Per patient. Not billable within 6 months of delivery of, interim, partial or complete denture. | Full mouth x-rays |
| D5421 | adjust partial denture-maxillary | 14-20 | | Yes | No | One of (D5421) per 12 Month(s) Per patient. Not billable within 6 months of delivery of, interim, partial or complete denture. | Full mouth x-rays |

| Prosthodontics, removable | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5422 | adjust partial denture - mandibular | 14-20 | | Yes | No | One of (D5422) per 12 Month(s) Per patient. Not billable within 6 months of delivery of, interim, partial or complete denture. | Full mouth x-rays |
| D5511 | repair broken complete denture base, mandibular | 14-20 | | No | No | | |
| D5512 | repair broken complete denture base, maxillary | 14-20 | | No | No | | |
| D5520 | replace missing or broken teeth - complete denture - per tooth | 14-20 | Teeth 1 - 32 | No | No | | |
| D5610 | repair resin denture base | 14-20 | Per Arch (01, 02, LA, UA) | No | No | | |
| D5620 | repair cast framework | 16-20 | Per Arch (01, 02, LA, UA) | No | No | | |
| D5630 | repair or replace broken retentive/clasping materials per tooth | 14-20 | Teeth 1 - 32 | No | No | | |
| D5640 | replace missing or broken teeth – partial denture – per tooth | 14-20 | Teeth 1 - 32 | No | No | | |
| D5650 | add tooth to existing partial denture – per tooth | 14-20 | Teeth 1 - 32 | No | No | | |
| D5660 | add clasp to existing partial denture | 14-20 | Teeth 1 - 32 | No | Yes | | |
| D5670 | replace all teeth and acrylic on cast metal framework (maxillary) | 16-20 | | No | Yes | Photograph Required | Photograph |
| D5671 | replace all teeth and acrylic on cast metal framework (mandibular) | 16-20 | | No | Yes | Photograph Required | Photograph |
| D5730 | reline complete maxillary denture (chairside) | 14-20 | | No | No | One of (D5730, D5731, D5750, D5751) per 2 Year(s) Per patient. | |
| D5731 | reline complete mandibular denture (chairside) | 14-20 | | No | No | One of (D5730, D5731, D5750, D5751) per 2 Year(s) Per patient. | |
| D5740 | reline maxillary partial denture (chairside) | 14-20 | | No | No | Not billable within 6 months of D5211, D5212, D5213,D5214, D5225, D5226 | |

| Prosthodontics, removable | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5741 | reline mandibular partial denture (chairside) | 14-20 | | No | No | Not billable within 6 months of D5211, D5212, D5213,D5214, D5225, D5226 | |
| D5750 | reline complete maxillary denture (laboratory) | 14-20 | | No | No | One of (D5730, D5731, D5750, D5751) per 2 Year(s) Per patient. | |
| D5751 | reline complete mandibular denture (laboratory) | 14-20 | | No | No | One of (D5730, D5731, D5750, D5751) per 2 Year(s) Per patient. | |
| D5760 | reline maxillary partial denture (laboratory) | 14-20 | | Yes | No | Bill if sent to outside laboratory; Not billable for 6 months after inserting any partial denture | |
| D5761 | reline mandibular partial denture (laboratory) | 14-20 | | Yes | No | Bill if sent to outside laboratory; Not billable for 6 months after inserting any partial denture | |
| D5810 | interim complete denture-maxillary | 7-20 | | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D5811 | interim complete denture-mandibular | 7-20 | | No | Yes | Narrative of Medical Necessity, Xray Required | Full mouth x-rays |
| D5820 | interim partial denture (maxillary) | 7-20 | | No | Yes | Includes retentive / clasping material, rests, and teeth. | Full mouth x-rays |
| D5821 | interim partial denture-mandibular | 7-20 | | No | Yes | Includes retentive / clasping material, rests, and teeth. | Full mouth x-rays |
| D5850 | tissue conditioning, maxillary | 14-20 | | No | No | Not billable within 6 months of any denture. | |
| D5851 | tissue conditioning,mandibular | 14-20 | | No | No | Not billable within 6 months of any denture. | |
| D5899 | unspecified removable prosthodontic procedure, by report | 7-20 | | No | Yes | Narrative of Medical Necessity, Xray Required | narr. of med. necessity, pre-op x-ray(s) |

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

| Maxillofacial Prosthetics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D5937 | trismus appliance (not for TMD treatment) | 1-20 | | No | Yes | Narrative of medical necessity. | narrative of medical necessity |
| D5986 | fluoride gel carrier | 1-20 | | No | Yes | For patients undergoing radiation. Narrative of Medical Necessity. | |
| D5991 | vesiculobullous disease medicament carrier | 1-20 | | No | Yes | Narrative of medical necessity. | narrative of medical necessity |
| D5999 | unspecified maxillofacial prosthesis, by report | 1-20 | | No | Yes | Narrative of medical necessity. | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.
Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.
Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.
Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.

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

| Prosthodontics, fixed | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D6211 | pontic-cast base metal | 14-20 | Teeth 6 - 11, 22 - 27 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6212 | pontic - cast noble metal | 14-20 | Teeth 6 - 11, 22 - 27 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6241 | pontic-porcelain fused to base metal | 14-20 | Teeth 6 - 11, 22 - 27 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6242 | pontic-porcelain fused-noble metal | 14-20 | Teeth 6 - 11, 22 - 27 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |

| Prosthodontics, fixed | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D6545 | retainer - cast metal fixed | 14-20 | Teeth 5 - 12, 21 - 28 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6751 | crown-porcelain fused to base metal | 14-20 | Teeth 5 - 12, 21 - 28 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6752 | crown-porcelain fused noble metal | 14-20 | Teeth 5 - 12, 21 - 28 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6791 | crown - full cast base metal | 14-20 | Teeth 5 - 12, 21 - 28 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6792 | crown - full cast noble metal | 14-20 | Teeth 5 - 12, 21 - 28 | No | Yes | One of (D6211, D6212, D6241, D6242, D6545, D6751, D6752, D6791, D6792) per 60 Month(s) Per patient per tooth. Allowable when missing only one anterior tooth in the maxillary or mandibular arch | Full mouth x-rays |
| D6930 | re-cement or re-bond fixed partial denture | 14-20 | | Yes | No | | narrative of medical necessity |
| D6980 | fixed partial denture repair | 14-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | Yes | No | | narrative of medical necessity |
| D6999 | fixed prosthodontic procedure | 14-20 | Teeth 1 - 32 | No | Yes | | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.
Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.
Reimbursement includes local anesthesia and post-operative care.
Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.
'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.
Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.
For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.
Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).
Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

| Oral and Maxillofacial Surgery | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D7111 | extraction, coronal remnants - primary tooth | 0-20 | Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Limited to primary dentition | |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Prior authorization required if ortho related. | |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Prior authorization required if ortho related. | |
| D7220 | removal of impacted tooth-soft tissue | 12-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Prior authorization required if ortho related. | |

| Oral and Maxillofacial Surgery | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D7230 | removal of impacted tooth-partially bony | 12-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. | |
| D7240 | removal of impacted tooth-completely bony | 12-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. | |
| D7241 | removal of impacted tooth-completely bony, with unusual surgical complications | 12-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. | |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. | |
| D7270 | tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | 5-20 | Teeth 1 - 32 | No | No | | |
| D7272 | tooth transplantation (inlcudes reimplantation from one site to another) | 5-20 | Teeth 1 - 32 | No | No | | |
| D7280 | Surgical access of an unerupted tooth | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required.Indicate need and if orthodontics related. | narr. of med. necessity, pre-op x-ray(s) |
| D7282 | mobilization of erupted or malpositioned tooth to aid eruption | 6-20 | Teeth 2 - 15, 18 - 31 | No | Yes | Narrative of Medical Necessity,Not covered for teeth #1, #16, #17, 32 | narrative of medical necessity |
| D7283 | placement of device to facilitate eruption of impacted tooth | 8-20 | Teeth 1 - 32 | No | Yes | Narrative of Medical Necessity, Xray Required.Indicate need and if orthodontics related. | narr. of med. necessity, pre-op x-ray(s) |
| D7310 | alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 14-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | No | One of (D7310) per 1 Lifetime Per patient per quadrant. | |

| Oral and Maxillofacial Surgery | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D7320 | alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 14-20 | Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) | No | No | One of (D7320) per 1 Lifetime Per patient per quadrant. | |
| D7510 | incision and drainage of abscess - intraoral soft tissue | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | No | | |
| D7511 | incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | 0-20 | | No | No | | |
| D7520 | incision and drainage of abscess - extraoral soft tissue | 0-20 | | No | No | | |
| D7521 | incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | 0-20 | | No | No | | |
| D7910 | suture small wounds up to 5 cm | 14-20 | | No | No | | |
| D7961 | buccal / labial frenectomy (frenulectomy) | 0-20 | | No | No | | |
| D7962 | lingual frenectomy (frenulectomy) | 0-20 | | No | No | | |
| D7970 | excision of hyperplastic tissue - per arch | 14-20 | Per Arch (01, 02, LA, UA) | No | Yes | Narrative of medical necessity. | narrative of medical necessity |
| D7971 | excision of pericoronal gingiva | 14-20 | Teeth 1 - 32 | No | No | | |
| D7999 | unspecified oral surgery procedure, by report | 0-20 | Teeth 51 - 82, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | No | Xray and Narrative of Medical Necessity. Enter tooth Number and CDT code for type of extraction in comment box. See Dental Provider Policy Manual. | narr. of med. necessity, pre-op x-ray(s) |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Participants under the age of 21 may qualify for orthodontic care under the program. Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8660.

Prior authorization is required for any comprehensive orthodontic case that meets the criteria listed below.
•Delaware Special Dental Orthodontic Form: Cases that qualify by exception must also be scored. All items on the form must be fully completed or the case will be denied.
•Treatment plan that must include:
-Cost of treatment
-Treatment plan
•Photographs
•Panoramic radiograph
•Cephalometric radiograph
•Digital models
•Orthognathic surgery cases: The member must be evaluated by an oral surgeon prior to submission for comprehensive orthodontics. The oral surgeon’s report must be submitted with the prior authorization for review. If this report is not included, the case will be denied.

Prior to application of braces, the orthodontist must assure that the member has seen a general dentist and is free of all active caries, periodontal disease and maintains good oral hygiene. Members who have poor oral hygiene, active caries, or have not been to a dentist for their six-month checkup will be denied orthodontic treatment until such time as their condition changes: See the Delaware Special Dental Orthodontic Evaluation Form and guidance when scoring. No treatment should begin without an approval from DentaQuest.

Only submit a prior authorization to DentaQuest for comprehensive orthodontics when the following criterion is met.
•Permanent dentition only. Primary and transitional dentition cases will not be reviewed.
•A score of 26 or above on the Delaware Special Dental Orthodontic Evaluation Form.
•When a score of 26 has not been reached but one of the 5 exceptions can be clearly demonstrated.
•When an impacted permanent tooth has caused visible damage to the root of another permanent tooth. (Must be included in the report as well as demonstrate existing damage to root of tooth.)
•When a child has been approved for orthodontic treatment by another state Medicaid program and has been receiving active and consistent treatment.

Billing
The charge for initial exam, radiographs and study models for approved cases should be submitted under procedure code D8660. The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service. In addition, the provider should verify eligibility of the Participant for the entire course of treatment. The Participant must be eligible on the dates each service is rendered, including banding, adjustments, debanding, and retainers. If a recipient's eligibility ends before the conclusion of treatment.

If a member becomes ineligible during treatment and before full payment is made, DentaQuest will pay the balance of any remaining treatment up to the approved case rate. To receive the remaining balance for members that are ineligible but remain in treatment, providers must submit the claim using D8999 with the last service date the patient was eligible and a narrative stating the request.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime. To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). In order to receive reimbursement for orthodontic adjustments, provider must bill for each date of service treatment was rendered. Only one D8670 allowed per month and 24 D8670's allowed per case per lifetime. If a Participant fails to keep an appointment for two consecutive appointments, the dental office must notify DentaQuest.

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

| Orthodontics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D8020 | limited orthodontic treatment of the transitional dentition | 7-14 | | Yes | No | Submit Panorex and photographs with claim | photos, xrays, treatment plan |
| D8090 | comprehensive orthodontic treatment of the adult dentition | 10-20 | | No | Yes | Delaware Special Dental Orthodontic Form Required.Photographs Required and Treatment Plan. Xray's Required (Panoramic radiograph, Cephalometric radiograph),Digital Model Required.See Dental Provider Policy Manual. | narrative of medical necessity |
| D8660 | pre-orthodontic treatment examination to monitor growth and development | 10-20 | | No | No | See Dental Provider Policy Manual | |
| D8670 | periodic orthodontic treatment visit | 10-20 | | No | Yes | Twenty-Four of (D8670) per 1 Lifetime Per patient. Maximum of 24 periodic visits | |
| D8680 | orthodontic retention (removal of appliances) | 8-20 | | Yes | No | Not payable when there is approval for a D8090 or D8020. | |
| D8703 | Replacement of lost or broken retainer - maxillary | 10-20 | | No | Yes | | |
| D8704 | Replacement of lost or broken retainer - mandibular | 10-20 | | No | Yes | | |
| D8999 | unspecified orthodontic procedure, by report | 10-20 | | No | Yes | | |

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain. Procedure code D9110 - palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits. Acceptable conditions include:
* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior,the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day. Reimbursement for local anesthesia is included in the fee for the procedures. Procedure code D9310 - consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. There will not be a separate reimbursement for a consultation. Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs. Procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.
Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

| Adjunctive General Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9110 | palliative treatment of dental pain - per visit | 0-20 | | No | No | Two of (D9110) per 1 Year(s) Per patient. Provide narrative; may not be used in conjunction with restorative code on same tooth; may not be billed with D0120 or D0150, or denture repair services; limited to twice per year. | narrative of medical necessity |
| D9222 | deep sedation/general anesthesia first 15 minutes | 0-20 | | Yes | No | | narrative of medical necessity |

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Adjunctive General Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9223 | deep sedation/general anesthesia - each subsequent 15 minute increment | 0-20 | | Yes | No | | narrative of medical necessity |
| D9230 | inhalation of nitrous oxide/analgesia, anxiolysis | 0-20 | | Yes | No | | narrative of medical necessity |
| D9239 | intravenous moderate (conscious) sedation/analgesia- first 15 minutes | 0-20 | | Yes | No | | narrative of medical necessity |
| D9243 | intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | 0-20 | | Yes | No | | narrative of medical necessity |
| D9248 | non-intravenous moderate sedation | 0-20 | | Yes | No | | narrative of medical necessity |
| D9420 | hospital or ambulatory surgical center call | 0-20 | | Yes | No | Code required when seen in OR or at other providers office | narrative of medical necessity |
| D9440 | office visit - after regularly scheduled hours | 0-20 | | Yes | No | One of (D9440) per 1 Day(s) Per patient. | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain. Procedure code D9110 - palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits. Acceptable conditions include:
* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior,the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day. Reimbursement for local anesthesia is included in the fee for the procedures. Procedure code D9310 - consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. There will not be a separate reimbursement for a consultation. Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs. Procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.
Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

| SPU Authorizations D9500 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9500 | Medical Anesthesia Services | 0-20 | | No | Yes | | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain. Procedure code D9110 - palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits. Acceptable conditions include:
* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior,the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day. Reimbursement for local anesthesia is included in the fee for the procedures. Procedure code D9310 - consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. There will not be a separate reimbursement for a consultation. Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs. Procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.
Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

| Adjunctive General Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9610 | therapeutic drug injection, by report | 0-20 | | Yes | No | Note medication on claim | narrative of medical necessity |
| D9612 | therapeutic drug injection - 2 or more medications by report | 0-20 | | Yes | No | Note medication on claim | narrative of medical necessity |
| D9920 | behavior management, by report | 0-20 | | No | No | | |
| D9930 | treatment of complications (post-surgical) - unusual circumstances, by report | 0-20 | | Yes | No | Narrative of medical necessity. | narrative of medical necessity |

## Exhibit B Benefits Covered for AmeriHealth Caritas DE - DSHP (Medicaid 20 & Under) / AmeriHealth Caritas DE - DHCP (18 & Under) / ACDE - DSHP Plus (LTSS) (Medicaid 20 & Under) / ACDE - DSHP Plus (CW) (Medicaid 20 & Under)

| Adjunctive General Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age Limitation** | **Teeth Covered** | **Pre-payment Review Required** | **Prior Authorization Required** | **Benefit Limitations** | **Documentation Required** |
| D9944 | occlusal guard--hard appliance, full arch | 0-20 | Per Arch (01, 02, LA, UA) | Yes | No | | narrative of medical necessity |
| D9986 | Missed Appointment | 0-20 | | No | No | Missed Appointments | |
| D9999 | unspecified adjunctive procedure, by report | 0-20 | | No | Yes | | narrative of medical necessity |

AmeriHealth Caritas Delaware - DSHP Medicaid (20 and Under)