ILLINOIS CARDINAL

DentaQuest

PROGRAM UPDATES FOR ILLINOIS PROVIDERS IN THE DENTAQUEST NETWORK

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Welcome to Illinois Cardinal

IN THIS ISSUE

Illinois Provider Newsletter designed to keep you abreast!

DentaQuest will be providing updates to plan benefits and changes, as well as educational pieces in this newsletter for our provider network, bi-annually. Watch for the newsletter to arrive either by email or fax. Please reach out to your provider partner to make sure we have an updated email and/or fax number.

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Dental Groups are Required to Complete an IMPACT Revalidation

Did you revalidate your dental group?

Revalidation is federally mandated for all dental providers, including **Dental Groups**. Your revalidation period and status can be viewed in the Basic Information step of the IMPACT enrollment. Your revalidation must be submitted by the end date of the revalidation period. Automated revalidation email notifications are sent 90 and 30 days prior to the revalidation period end date to the email addresses listed in the Basic Information. **Please ensure the email addresses listed are correct.**

If your dental group is currently inactive, it is critical that you **take the following actions immediately to avoid potential recoupment for any dates of service billed while inactive**.

- Contact IMPACT to request that your account be opened and an Intermediate Revalidation Cycle be added. This will allow you to access your enrollment information to submit the required revalidation and begin the reactivation process for your group.
- Complete and submit your revalidation as soon as possible. The revalidation CANNOT be submitted the same day your enrollment is reopened by IMPACT staff, but it must be submitted by the new cycle end date.

Your enrollment status will be in a temporary active status while the revalidation is under review. Once the review is completed and approved, your enrollment status will be reactivated; however, there may be a gap in eligibility due to not revalidating timely.

Please be aware that failure to initiate and complete the revalidation process may result in recoupment of all claims for dates of service submitted during the inactive time frame.

If you have questions regarding the revalidation process you can view the revalidation resources on our website or call to speak with an IMPACT enrollment specialist on Monday, Tuesday, and Friday from 8:30 to 4:30.

Stay Compliant & Connected

Illinois Provider Training Opportunities

Staying up to date with training requirements is essential to maintaining compliance and delivering high-quality care. All participating Illinois providers must complete annual training by December 31, 2026. Required topics include General Compliance, Fraud, Waste & Abuse, Cultural Competency & Non-Discrimination, and the Annual DentaQuest Provider Training. These trainings can be completed anytime on the IL provider website https://www.dentaquest.co2653222m/en/providers/illinois.

Live provider training sessions are available throughout the year and can be used to fulfill annual training requirements ensuring alignment with program standards. The full schedule for the remainder of the year is outlined below and is available on the IL provider website https://www.dentaquest.com/en/providers/illinois.

Title	Date/Time	Meeting Link
Annual Provider Training	Wednesday, July 15th from 12:30-1:30 pm CST	Join the Meeting Meeting ID: 297 800 804 796 08 Passcode: 2kU3d8bn
HFS Specific Training	Tuesday, August 18th from 12:30-12:45 pm CST	Join the Meeting Meeting ID: 298 115 028 89 Passcode: ML75sc9W
New Provider Training	Wednesday, November 18th from 12:30-1:30pm CST	Join the Meeting Meeting ID: 218 526 121 126 44 Passcode: ks7gR6u6

Once complete, providers must submit an attestation by TIN via Annual Provider Training Attestation 2026 Survey. Timely completion and attestation are required to remain in compliance.

Short on time? Monthly Micro Learning Sessions offer quick, 15-minute trainings focused on key updates and best practices. These sessions are designed to keep your team informed, improve workflows, and enhance patient care—without disrupting your schedule.

The calendar and invite link are available on the IL provider website https://www.dentaquest.com/en/providers/illinois, and reminder invitations will be sent prior to each session.

Access and Availability Survey Reminder

Supporting timely care through quarterly outreach and appointment access standards

DentaQuest conducts quarterly outreach surveys to confirm provider availability and ensure members have timely access to care. During these calls, you may be asked to verify:

- Emergency appointment availability
- Urgent care appointment timeframes
- Routine care scheduling (within required days)
- Therapeutic care scheduling (within required days)
- New patient initial appointment timelines
- Follow-up appointments scheduled within required timeframes after treatment

As a Medicare Advantage provider contracted in Illinois, you are expected to meet these access and availability standards to support member care and compliance requirements.

We understand there may be exceptional circumstances that make meeting these timeframes challenging. If your practice is unable to meet these standards, please contact your Provider Engagement (PE) representative for support.

Thank you for your continued partnership and commitment to providing timely, high-quality care to our members.

Claims Tips

Tips for smooth claims submission and processing

To help ensure faster processing and reduce claim denials, we have outlined key reminders for submitting claims correctly. Taking a few extra steps upfront can save time and prevent reworking later.

Corrected Claims: Getting It Right the Second Time

If you discover an error on a submitted claim, it is important to follow the correct process. Submitting a corrected claim without first voiding the original may result in duplicates or denials.

- Step 1: Request to void the original claim through the provider portal or by calling Customer Service at 800-508-6780
- Step 2: Allow 48–72 business hours for the void to complete and always check to make sure the claim shows voided.
- Step 3: Submit a new claim with corrected information once original claim shows as voided.

OFFICE REFERENCE MANUALS:

- View all plan benefits at the procedure code level
- View all document requirements at the procedure code level
- Outlines clinical criteria
- Understand the appeal process
- Guidelines for billing noncovered services to members
- Administrative forms to incorporate in your practice
- Important contact information

All Office Reference Manuals (ORMs) can be found on the Provider Web Portal

Non-Covered Services: Protect Your Practice

- Before providing services that are not covered under a member's plan, you MUST obtain a signed agreement from the member in advance. Without this documentation, you may not be able to bill the member
- Ensure the agreement found in the ORM includes the procedure code, service description, and applicable fees.

Timely Filing, Pre-Authorizations and Required Documentation Matters

- To avoid claim denials Submit claims within 180 days of the date of service, or primary EOB date.

- Certain procedures require supporting clinical documentation, such as X-rays, chart notes, or any additional records outlined in the ORM.
- IMPORTANT: Even if you have an approved prior authorization, you must resubmit all required documentation with the claim.
- Prior authorization requirements vary by procedure and plan. Always reference the ORM benefit grid for service limitations and authorization requirements; this helps prevent unnecessary delays or denials. Authorizations can be submitted via the provider web portal (PWP), electronic submission, and mail.

Date of Service (DOS):

- When searching for a member on the portal always enter the correct Date of Service (DOS).
- This ensures accurate eligibility and correct plan details are applied to the claim.
- Accurate submission of claims is key to timely reimbursement. By following these tips and referencing your Office Reference Manual (ORM), you can help streamline processing and reduce avoidable denials.

PROVIDER WEB PORTAL:

- Providers.DentaQuest.com
- Check member eligibility & history
- View and download member rosters for Dental Home programs
- Submit and view status of claims and prior authorizations
- View payment and print EOBs
- Access office reference manuals and other provider resources
- Contact DentaQuest
- Find A Dentist
- News & Announcements

New Codes Added to the IL Medicaid Dental Program

HFS has implemented three new procedure codes for the dental program

Effective July 1, 2026, D7471, D7472, and D7473 have been implemented by HFS to the Illinois Medicaid Dental Program. Below are the new covered procedures, benefit limitations, and reimbursement rates.

Code	Description and Limitation	Reimbursement Rate
D7471	Removal of Lateral Exostosis- Allowed once per quadrant per lifetime.	$175.22
D7472	Removal of Torus Palatinus- Allowed once per lifetime.	$213.76
D7473	Removal of Torus Mandibularis- Allowed once per quadrant per lifetime.	$203.25

Full benefit limitation details are available on the Covered Benefits Exhibit A located on Healthcare and Family Services' website.

Grow Your Practice with IL D-SNP Opportunities

Why Participate in D-SNP plans?

Illinois dental providers are invited to participate in Aetna Better Health and Humana Benefit Plan of Illinois Dual Eligible Special Needs Plans (D-SNPs)—designed for members eligible for both Medicare and Medicaid.

- DSNP plans include annual Medicare dental maximums
- Most covered services are paid at 100%, reducing member out-of-pocket costs
- Improved access leads to stronger utilization and continuity of care

To participate, providers must be credentialed through IMPACT as an Illinois Medicaid provider and DentaQuest as an Illinois Medicare dental provider. Both enrollments are required to serve DSNP members. Expand your patient base and support Illinois' dual-eligible communities by starting your credentialing today at Dentist Profile.

FQHC Electronic Claim Process

Claim submission requirements when submitted via your clearinghouse

To be in compliance with the Dental Office Reference Manual (DORM), DentaQuest will continue to enforce the existing claim submission requirements for FQHCs outlined in the DORM. These requirements are not new requirements; we are simply ensuring all claims processed are in accordance with existing guidelines.

Must be a billable dental encounter, which is defined as a face-to-face visit with a dentist, dental hygienist under the supervision of a dentist or a public health dental hygienist (PHDH).

Only one dental encounter per patient per day is eligible for reimbursement.

All dental encounters must have D0999 on the first line of the claim (LOS #1) or the claim will be rejected, and no encounter rate will be paid to the FQHC.

- Submit codes for every procedure performed on the encounter claim.
- Ensure each code has its corresponding tooth numbers, quads, and arches indicated.
- X-ray services may not be billed as an encounter.
- Include applicable authorization numbers, as prior authorizations are required for all dental services.
- Include all documentation requirements.
- Ensure that Box 38 Place of Treatment is marked as "Other".
- Ensure that Box 49 has the FQHC business NPI and not the Individual NPI.
- Ensure that Box 54 has the Servicing Provider NPI and not the Business NPI.

If a claim is rejected due to not meeting FQHC billing criteria, the following standardized error codes based on the scenario of rejection will be sent to you via your clearinghouse:

- A6:454 – Missing procedure code for services rendered. This occurs when a claim is submitted with only D0999 and no other procedures.
- A7:402 and A7:583 – Invalid line item charge amount. This occurs when the service lines for the corresponding procedures do not include a billed amount greater than $0.
- A7:481 – Invalid claim submission format. This is when the encounter code (D0999) is not billed on the first service line.

2026 Anesthesia Code Changes

Reminder to transition from D9248 to updated CDT 2026 sedation codes

Reminder: **Effective January 1, 2026**, CDT Code D9248 was deleted and replaced with four new more specific codes. These changes were implemented by the ADA to ensure more accurate detail for documentation and reporting. Below are the covered replacement CDT Codes for D9248 and their reimbursement rate.

Code	Description	Reimbursement Rate
D9244	In-office administration of Minimal sedation – single drug - enteral	$150.00
D9245	Administration of Moderate sedation – enteral.	$150.00
D9246	Administration of moderate sedation - non-intravenous parenteral-first15-minute increment, or any portion thereof.	$75.00
D9247	Administration of moderate sedation — non-intravenous parenteral — each subsequent 15-minute increment, or any portion thereof.	$75.00

ACCESS AND AVAILABILITY STANDARDS:

- Members should be seen within 30 minutes of appointment check-in
- Emergency Appointments should be scheduled within 24 hours to control bleeding, infection, imminent tooth loss, or treatments of injuries to teeth.
- Urgent Appointments should be scheduled within 48 hours to address a chipped tooth, sensitivity, and mild pain.
- Restorative, Periodontics, or Orthodontics should be addressed with 14 days of diagnosis.
- Routine Care appointments should be scheduled within 30 days of the member's request.

Additionally, Permit A or B is required and the full benefit limitation details are available on the Covered Benefits Exhibit A located on Healthcare and Family Services' website.

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All Kids School Based Dental Program

The 2026-2027 School Year

All dentists and public health dental hygienists who will be providing services during the 2026–2027 All Kids School-Based Dental Program (August 31, 2026, through July 1, 2027) are required to complete one mandatory training course. This training must be completed prior to rendering any dental services in the 2026–2027 school year to meet program approval requirements.

We invite all dental professionals, administrative staff, those interested in learning more about the program, and anyone considering joining the program to attend one of the training sessions.

Wednesday, August 5, 2026	**11:00-12:00PM (CST)**	By Web: Click here to Join By Phone:415-655-0002 meeting #2861 935 0496
Friday, August 7, 2026	**11:30-12:30PM (CST)**	By Web: Click Here to Join By Phone: 415-655-0002 meeting #2631 916 2355
Friday, August 14, 2026	**12:00-1:00PM (CST)**	By Web: Click Here to Join By Phone: 415-655-0002 meeting #2870 254 7874

Directory Validation

Is your office information up to date?

We appreciate your assistance in helping us maintain accurate practice information. Your timely response to our outreach is greatly appreciated. We will continue to contact each practice to verify the practice's demographic information, plans accepted, and practicing provider information.

If your practice has underwent any changes recently, you will need to complete the Standard Update form found online at Update your information | DentaQuest and submit your changes to StandardUpdates@greatdentalplans.com as well as updating your information in IMPACT.

It is important to keep all provider information accurate and current to not only serve our members, but to best serve you. Incorrect information can lead to missed notifications, claim denials, credentialing delays, and more.

Is Your Member Eligible?

Verifying eligibility is essential to ensuring proper coverage and avoiding claim issues

The Medical Electronic Data Interchange (MEDI) system is your primary resource and source of truth for verifying Illinois Medicaid eligibility, as it reflects real-time state data. Always verify eligibility on the date of service, as coverage can change daily. Be sure to review all sections carefully to identify the assigned Medicaid plan and any third-party liability (the member's primary insurance), when applicable. If you do not already have access, you can register at the IL HFS Website to get started (MEDI Home | HFS).

The DentaQuest Provider Web Portal complements MEDI by providing additional details such as coordination of benefits, plan information, benefits, annual maximums, and claims history. However, it should be used as a secondary resource. Due to potential data migration delays, discrepancies may occur. If differences are identified between MEDI and the DentaQuest Provider Web Portal, rely on MEDI first and escalate the issue to your assigned Provider Partner by submitting the MEDI sheet via email for further investigation.

Please note: Do not submit claim appeals for denials related to member eligibility.

NEW! Provider Cost Savings Program

Save on Practice Essentials with Provider Discounts

Running a dental practice means balancing quality care with cost management—and DentaQuest is here to help. We have partnered with leading dental product vendors to offer exclusive discounts on the supplies and equipment your practice uses every day. From routine materials to specialized items, these savings are designed to support your practice and reduce overhead costs.

These discounts are part of our commitment to making your work easier—so you can focus more on patient care and less on administrative tasks.

👉 Explore available discounts:
https://www.dentaquest.com/en/providers/provider-discounts