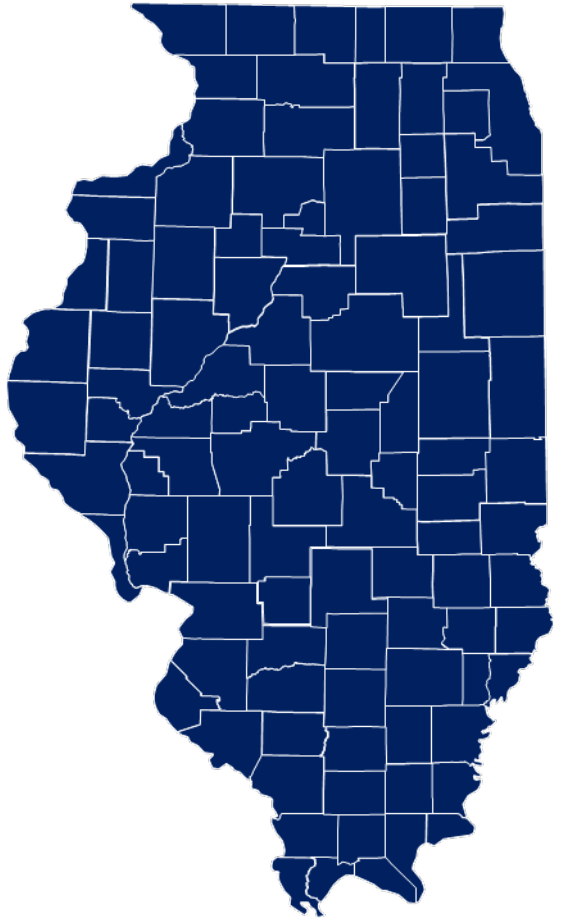
HFS NEW PROVIDER TRAINING

2026

DentaQuest
a Sun Life company

Agenda

- False Claims Act
- Whistleblower Protection
- HIPAA Guidelines
- Fee for Service Dental Program Overview
- Office Reference Manual
- HFS Provider Notices Subscription
- Maintaining Accurate Provider
- IMPACT
- IMPACT Revalidation
- Provider Web Portal Updates
- Claims and Authorization Submission
- Non-Covered Services
- HLD Score Sheet Update
- Provider Appeals
- Peer to Peer
- All Kids School Based Dental Program
- 2026 CDT Code Updates
- FAQ
- Claims Tips
- Tools and Resources
- Attestation



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False Claims Act (FCA)

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. Liability occurs when an individual:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

See 31 United States Code (USC) Sections 3729–3733.

Whistleblower Protection

DentaQuest protects individuals who make good faith reports of potential instances of Non-Compliance or FWA. Federal and State “whistleblower” protection laws ensure that persons who expose information or activity that is deemed illegal, dishonest, or violates professional or clinical standards will not be retaliated against.

Whistleblowers are:

- Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent of the money collected.

Health Insurance Portability and Accountability Act

Requirements

- **Dentists** must ensure that patient health information (PHI) is properly safeguarded. This means implementing physical, administrative, and technical safeguards to protect patient records and communications.
- **Dental offices** are required to establish a set of security measures designed to protect electronic PHI (ePHI).
- **Dentists** must utilize standardized electronic transactions for billing and record-keeping.
- **All dental office staff** must receive training on HIPAA regulations and best practices.
- In the event of a breach involving unsecured PHI, dentists must follow the correct procedures for notifying affected individuals and relevant authorities within the required timeframe.

HIPAA Guidelines for the Dental Office to remain compliant

- **Dental Offices*:*** Must secure Protected Health Information (PHI), which includes any oral or written information related to an individual's health condition.
- **Compliance Officer:** Dental practices should appoint an officer responsible for overseeing HIPAA compliance within the office.
- **Risk Assessments:** Regular evaluations should be conducted to identify any potential vulnerabilities.
- **Business Associates:** Those who have access to patient information through the dental office must also comply with HIPAA regulations.
- **Communication:** Policies must be in place that dictate how PHI is communicated within the office and to external parties, such as family members or insurance providers.

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Fee For Service (FFS) Dental Program Overview

- Administered by the IL Department of Healthcare and Family Services (HFS)
- Provides dental services to children and adults who are enrolled in the Medical Fee-For-Service Program
- Customers can not be charged for covered services.
- Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage.
- Customer eligibility can be verified through:
  - the Medi site (MEDI Home | HFS)
  - The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 800-842-1461
- Coverage includes preventative, diagnostic, restorative, and orthodontics. Please note that orthodontics is a child benefit only.
  - Dental Benefit Schedule is located on HFS website
  - Dental Fee Schedule is located on the HFS website
- Offers a Spenddown Program
  - Spenddown program provides coverage to customers who would otherwise be ineligible because of income or assets that exceed the HFS Standards.
  - Spenddown works a little like an insurance deductible.
  - The amount of the spenddown is determined monthly based on income and assets of the customer.
- Requires all providers who render services under the FFS program be enroll as a Medicaid Provider via IMPACT (IMPACT Home | HFS).

HFS
Illinois Department of Healthcare and Family Services

Dental Providers that have questions about fee for service customers can contact DentaQuest HFS Dental Provider Hot Line at 1-800-842-1461 or send an email to HFS.Dental@illinois.gov.

Additional resources can be found at Dental | HFS.

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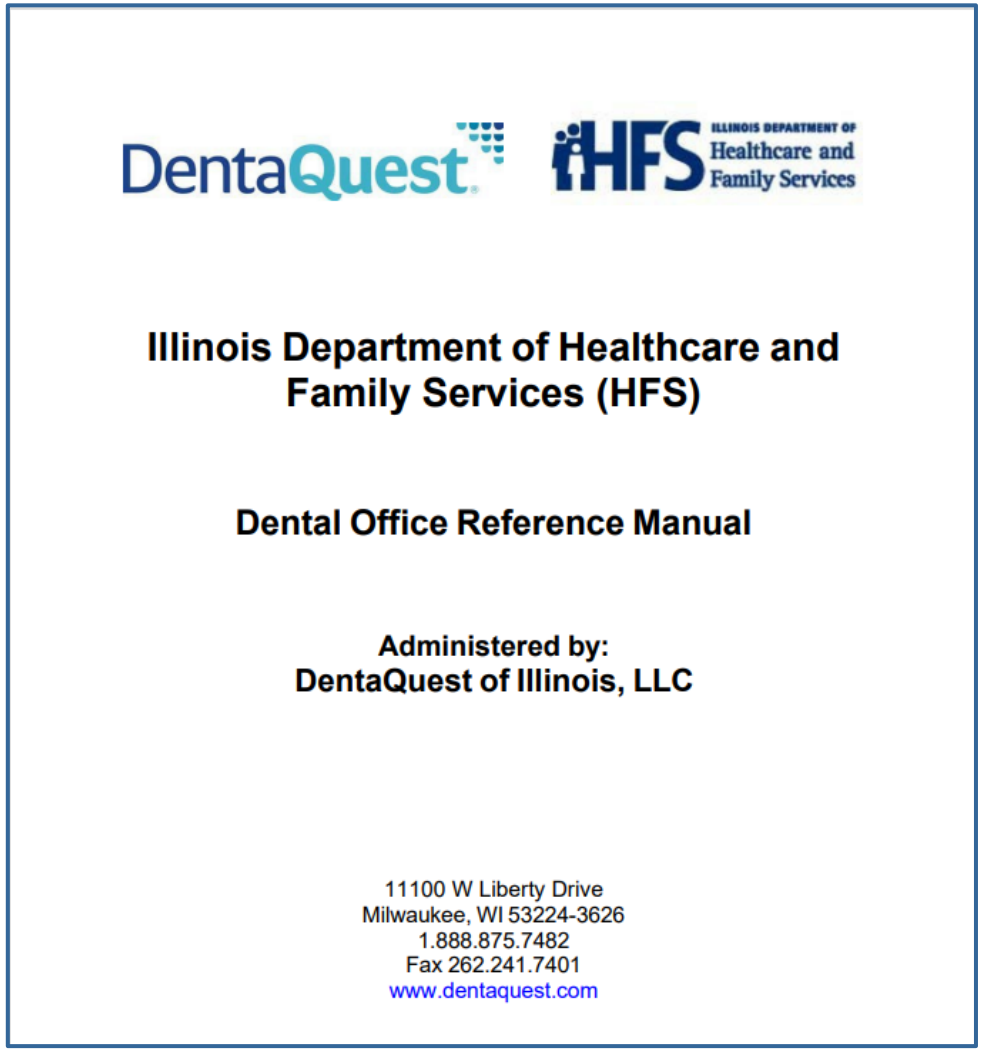
Office Reference Manual (ORM)

- Is your reference to FFS plan related information.
- Can be accessed through the Provider Web Portal (PWP) under “Resources” at providers.dentaquest.com.
- The ORM has a Table of Contents to help you quickly reference your question.
- There are Exhibits that list benefits covered under each plan.
- Each Exhibit will illustrate: Codes/Description/Teeth Covered/Authorization required/Benefit Limitations/Documentation Required.
- It is important to use the manual on the PWP, rather than print a manual, so that you don’t miss updates.
- Ensure every team member has access to the FFS ORM and understands how to utilize the document.



DentaQuest

HFS Illinois Department of Healthcare and Family Services

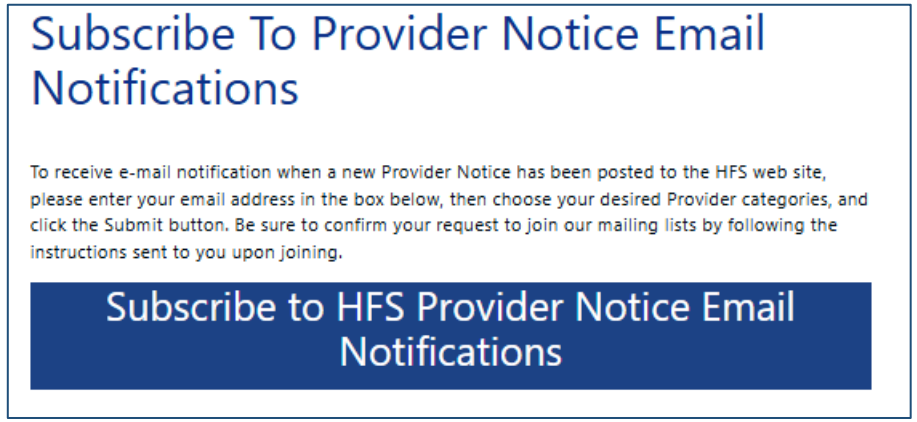
Illinois Department of Healthcare and Family Services (HFS)

Dental Office Reference Manual

Administered by:
DentaQuest of Illinois, LLC

11100 W Liberty Drive
Milwaukee, WI 53224-3626
1.888.875.7482
Fax 262.241.7401
www.dentaquest.com

Subscribe to HFS Provider Notices



- HFS sends out Provider notices and bulletins containing pertinent information for participating providers for dental services provided or for claims submitted for reimbursement.
- Notices inform providers and billing agents of possible revisions or clarifications of dental services. Bulletins include information about general policy and procedural updates for the various provider handbooks issued by the department.
- To receive e-mail notification when a new Provider Notice has been posted to the HFS web site, you need to subscribe to receive these notification.
- Click here to Subscribe To Provider Notice Email Notifications | HFS

Maintaining Accurate Provider Information in IMPACT

IMPACT

Illinois Medicaid Program
Advanced Cloud Technology

- All Medicaid Providers must be register and active in the IMPACT system to receive reimbursement for claims.
- All information must be kept current and accurate for both individual providers and businesses.

Need Assistance?

- Login issues related to a locked account:
  Email the IMPACT Login Helpdesk
  at IMPACT.Login@illinois.gov
- Issues with ILogin User accounts:
  Email the Okta team
  at DoIT.Okta.Support@illinois.gov
- Provider Enrollment issues:
  Contact a Provider Enrollment Specialist at
  1-877-782-5565.
- Monitor regularly to avoid delays.
  https://impact.illinois.gov/

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IMPACT Continued

Required fields for individuals that need to be up to date to ensure accurate claim processing

- **Name**- if your name is legally changed, you will need to provide documents indicating the change such as a court order, or marriage certificate etc. Note: if the name has been updated with your state license, NPI Registry or any other state agency you do not need to provide the document.
- **Home address-** if you move, you will need to update your residential address as soon as possible.
- **Specialty and Taxonomy Codes-** if you change your specialty or have a new taxonomy code.
- **License recertification date-** when you update your license, you will need to verify that the end date in IMPACT has been updated.
- **Billing Providers-** end date of company(s) you no longer work at and add new company(s) you have started working at.
- **Upload Documents-** If you have documents that would assist with the modification/revalidation you can upload the copy to this step.

It is the responsibility of the provider to modify their IMPACT enrollment.

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IMPACT Continued

Required fields for businesses that need to be up to date to ensure accurate claim processing

- **Location**- If the company address types, hours, or accommodations change.
- **Taxonomy code-** If a new taxonomy code needs to be added.
- **Ownership-** if there are changes to the list of Owner's, Managing Employees, and/or Board of Directors that include the following:
  - New owner types to be added
  - Removing (end dating) owner types
  - Home or company address has been changed.
- If the company is a Facility/Agency/Organization (FAO) they will need to **update a license**. If the company is a group a license is not required.
- **Upload Documents-** If the company believes they have documents that would assist with the modification/revalidation they can upload the copy to this step.

It is the responsibility of the provider to modify their IMPACT enrollment.

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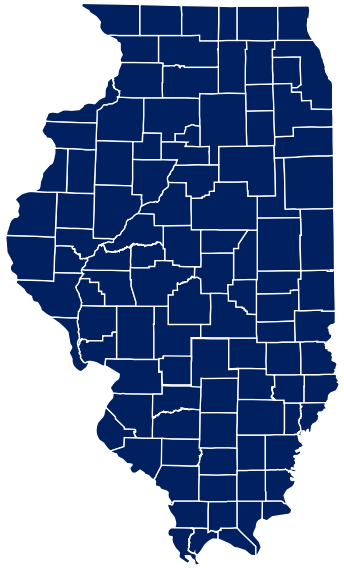
Mandatory IMPACT Revalidation

IL IMPACT



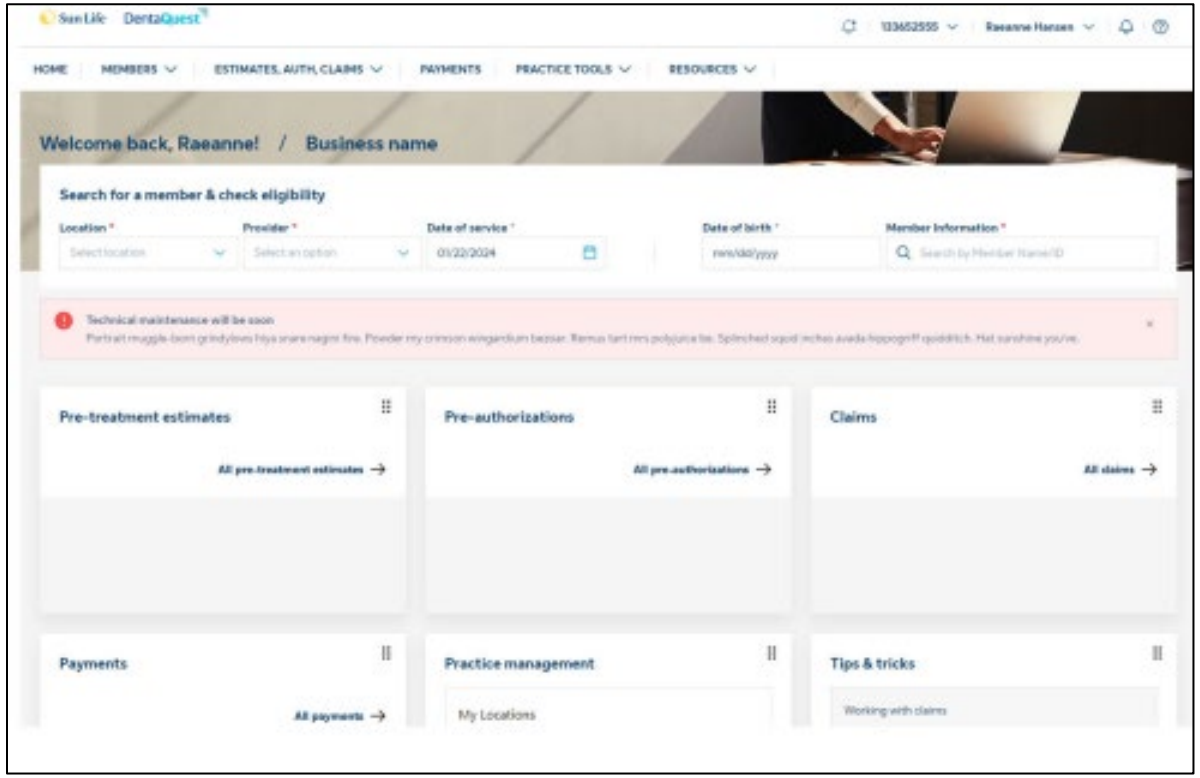
- Begin your revalidation: https://impact.illinois.gov/
- FAQ & step by step instructions: Provider Revalidation page
- Contact IMPACT directly at 877-782-5565 or by email IMPACT.Help@Illinois.gov for assistance.

Key Things to Know

- Enrollment in the IMPACT system is a federal requirement under the Affordable Care Act.
- Revalidations are required every 5 years based on their initial approval date.
- All IL Medicaid providers are required to revalidate.
- Providers and business entities who do not revalidate will be deactivated/disenrolled from the IL Medicaid program.
- Should a provider decide to reactivate their Illinois Medicaid enrollment beyond the expired revalidation cycle end date, the provider will be given an effective date based on when the re-enrollment is submitted. This will create a gap in the provider's eligibility.
- Providers will be ineligible for a retroactive enrollment.
- Provider notifications are sent to the registered email address within IMPACT. Make sure email address is up to date to receive notifications.

Provider Web Portal Updates

The Provider Web Portal has been undergoing significant enhancements designed to optimize operational efficiency and elevate the overall user experience.



Recent Provider Web Portal Updates include:

- Provider specific billed amounts have been added under “Tools”
- Ability to void and appeal claims
- All voided claims and appeals are visible under “Resources”
- Third Parties can now register

Claim and Prior Authorization Submission

Prior Authorizations

- Direct entry on the web
- Via Clearinghouse: Payer ID CX014
- By Fax: 262-241-7150
- Paper Authorizations can be sent by mail to:

  DentaQuest of Illinois, LLC
  Prior Authorizations
  PO Box 2906
  Milwaukee, WI 53201-2906

Claims

- Direct entry on the web
- Via Clearinghouse: Payer ID CX014
- By Fax: 262-241-7379
- Paper Claims can be sent by mail to:

  DentaQuest of Illinois, LLC
  Claims
  PO Box 2906
  Milwaukee, WI 53201-2906

Please note: DentaQuest adjudicates claims on a daily basis. The average time between receipt of a clean claim and check release is generally within 30 days.

Non-Covered Service Agreement

Available in the ORM on the Provider Web Portal

Attachment R

Agreement to Pay Non-Covered Services

Patient Name: _____

Recipient (Medicaid) ID: _____

Guarantor Name: _____

Relationship to Patient: _____

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

Non-Covered Services

Code	Description	Fee

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

_____ _____

Guarantor Signature Date

Guarantor Address:

_____

Street, Apt #

_____

City, State, Zip

Guarantor Phone

Home: _____

Cell: _____

Work _____

Effective April 28, 2025

Private reimbursement arrangements may be made only for Non-Covered Services (excluded procedures, denied for frequency limitations, or those with denied prior auths on file) with the prior knowledge and consent of the Customer.

The provider must obtain a signed agreement from the customer prior to rendering such service that indicates:

- The services to be provided
- DentaQuest and HFS will not pay for or be liable for said services
- **The amount the customer will be financially liable for**

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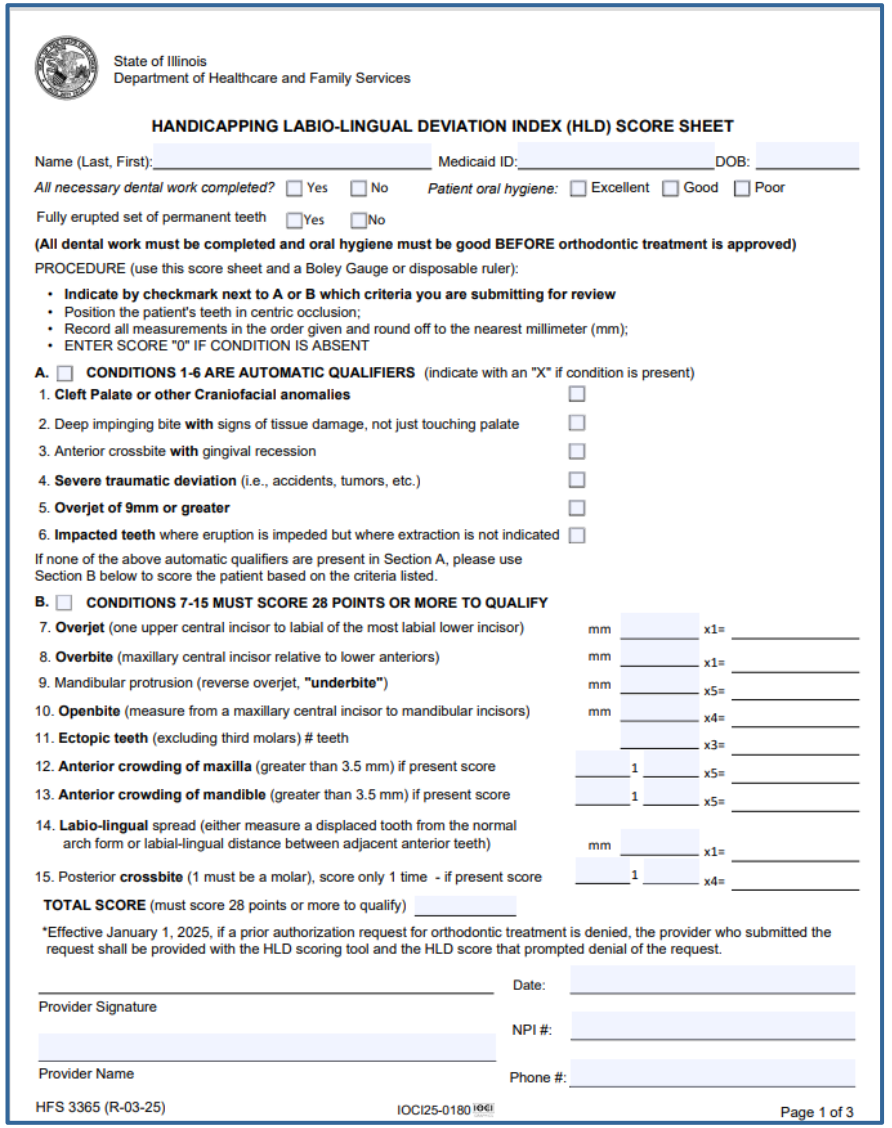
Handicapping Labio-Lingual Deviation Index (HLD) Score Sheet

Effective January 1, 2025, HFS expanded the HLD Tool to include additional automatic qualifiers.

- Cleft palate or other craniofacial anomalies
- Deep impinging bite with signs of tissue damage, not just touching palate
- Anterior crossbite with gingival recession
- Severe traumatic deviation (i.e., accidents, tumors, etc.)
- Overjet of 9mm or greater
- Impacted teeth where eruption is impeded but extraction is not indicated

If a prior authorization request for orthodontic treatment is denied, DentaQuest will supply to the provider who submitted the request the HLD scoring tool and the HLD score that prompted denial of the request.

The HLD scoring tool HFS 3365 and instructions can be found on the Medical Forms page of the HFS Website.



State of Illinois
Department of Healthcare and Family Services

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

Name (Last, First):_____ Medicaid ID:_____ DOB: _____

All necessary dental work completed? ☐ Yes ☐ No *Patient oral hygiene:* ☐ Excellent ☐ Good ☐ Poor

Fully erupted set of permanent teeth ☐ Yes ☐ No

(All dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A or B which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE "0" IF CONDITION IS ABSENT

A. ☐ **CONDITIONS 1-6 ARE AUTOMATIC QUALIFIERS** (indicate with an "X" if condition is present)

1. **Cleft Palate or other Craniofacial anomalies** ☐
2. Deep impinging bite **with** signs of tissue damage, not just touching palate ☐
3. Anterior crossbite **with** gingival recession ☐
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc.) ☐
5. **Overjet of 9mm or greater** ☐
6. **Impacted teeth** where eruption is impeded but where extraction is not indicated ☐

If none of the above automatic qualifiers are present in Section A, please use Section B below to score the patient based on the criteria listed.

B. ☐ **CONDITIONS 7-15 MUST SCORE 28 POINTS OR MORE TO QUALIFY**

7. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm _____ x1= _____
8. **Overbite** (maxillary central incisor relative to lower anteriors) mm _____ x1= _____
9. Mandibular protrusion (reverse overjet, **"underbite"**) mm _____ x5= _____
10. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm _____ x4= _____
11. **Ectopic teeth** (excluding third molars) # teeth _____ x3= _____
12. **Anterior crowding of maxilla** (greater than 3.5 mm) if present score _____ 1 _____ x5= _____
13. **Anterior crowding of mandible** (greater than 3.5 mm) if present score _____ 1 _____ x5= _____
14. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm _____ x1= _____
15. Posterior **crossbite** (1 must be a molar), score only 1 time - if present score _____ 1 _____ x4= _____

TOTAL SCORE (must score 28 points or more to qualify) _____

*Effective January 1, 2025, if a prior authorization request for orthodontic treatment is denied, the provider who submitted the request shall be provided with the HLD scoring tool and the HLD score that prompted denial of the request.

_____ Date: _____
Provider Signature

NPI #: _____

_____
Provider Name

Phone #: _____

HFS 3365 (R-03-25) IOCI25-0180 Page 1 of 3

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Provider Appeals

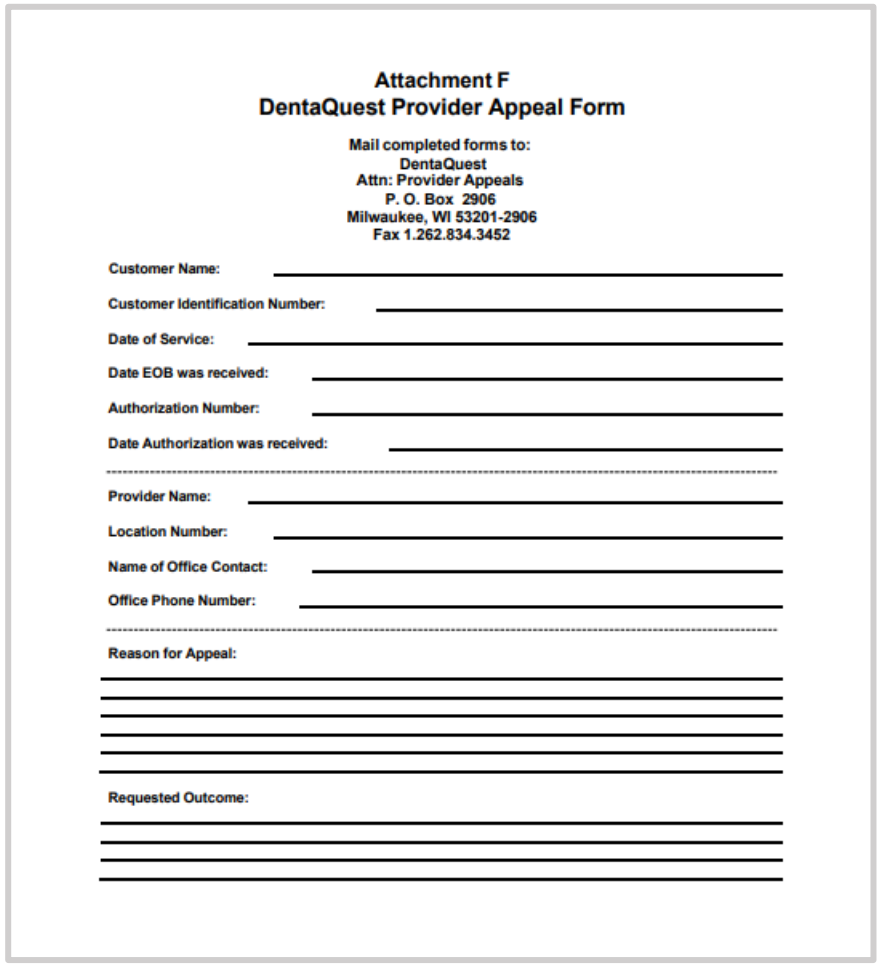
If a provider wishes to appeal any reimbursement decision, he/she must submit the appeal in writing, along with any necessary additional documentation within 180 days to:

DentaQuest of Illinois, LLC
Appeals
P. O. Box 2906
Milwaukee, WI 53201-2906

Provider appeals should be submitted on the DentaQuest Provider Appeal Form found in Attachment F of the ORM.

Provider appeals can also be submitted on the Provider Web Portal within the claim at https://providers.dentaquest.com/.

DentaQuest must respond to all provider appeals, in writing, within 30 days.



Attachment F
DentaQuest Provider Appeal Form

Mail completed forms to:
DentaQuest
Attn: Provider Appeals
P. O. Box 2906
Milwaukee, WI 53201-2906
Fax 1.262.834.3452

Customer Name: _____

Customer Identification Number: _____

Date of Service: _____

Date EOB was received: _____

Authorization Number: _____

Date Authorization was received: _____

Provider Name: _____

Location Number: _____

Name of Office Contact: _____

Office Phone Number: _____

Reason for Appeal:

_____
_____
_____
_____
_____
_____

Requested Outcome:

_____
_____
_____
_____

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Peer to Peer Requests

In lieu of appealing, should a provider have questions about a clinical denial, providers can request a Peer-to-Peer consultation. The intent of the Peer to Peer is to review edits, policies, procedures, and denial codes. The participating provider will have the opportunity to ask questions and gain clarity.

To make a Peer-to-Peer Request, a provider should submit the request on the DentaQuest Provider Portal.

Call Request and include:

- Provider name.
- Authorization/Claim number to discuss.
- Service Line numbers listed.
- Contact phone number for provider.
- Time zone.
- Time of day provider is available to receive the call.

All Kids School Based Dental Program

- The All Kids School-Based Dental Program allows dental providers to provide out-of-office delivery of preventive dental services in a school setting to children ages 0-18.
- The All Kids School-Based Dental Program school year is recognized as August 31st - July 31st .
- Participation brings care directly to students who need it most.
- There is a need for additional school providers.
- Providers who wish to participate as an All Kids School-Based Dental Program can email HFS.dental@illinois.gov for additional information how to sign up.

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2026 CDT Code Changes Effective January 1, 2026

- D9248 was deleted and replaced by more specific codes based on the level of sedation.
- Six new dental codes were added.

Benefit limitations and comprehensive descriptions of the new codes, can also be found within the benefit grid in the ORM.

Procedure Code	Description	Age Limitation	Benefit Limitation	Auth Required	Standard Rates effective 1/1/2026
D9224	Administration of general anesthesia with advanced airway – first 15-minute increment (or any portion thereof)	0-20 21 and above	One of (D9222, D9224, D9239) per 1 Day Per Business. Permit B is required. Not allowed on the same date of service with, D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247.	Yes	$284.62
D9225	Administration of general anesthesia with advanced airway – each subsequent 15-minute increment (or any portion thereof).	0-20 21 and above	Permit B is required. Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247. Each 15-minute increment is based on medical necessity	Yes	$284.62
D9244	Minimal sedation – single drug (enteral)	0-20 21 and above	Not allowed on same date of service as D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9245, D9246, or D9247. Limit One Per Date of Service.	Yes	$150.00
D9245	Moderate sedation – enteral.	0-20 21 and above	Not allowed on same date of service as D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9245, D9246, or D9247. Limit One Per Date of Service.	Yes	$150.00
D9246	Moderate sedation – non-IV parenteral (first 15 min).	0-20 21 and above	Not allowed on same date of service as D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9245, D9246, or D9247. Limit One Per Date of Service.	Yes	$75.00
D9247	Moderate sedation – non-IV parenteral (each subsequent 15 min).	0-20 21 and above	Not allowed on same date of service as D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9245, D9246, or D9247. Limit One Per Date of Service.	Yes	$75.00

Frequently Asked Questions

What fee can I charge for a non-covered service?

- When you bill for a service code that is non-covered and the service code is noted on the member's plan (i.e. denied for frequency limitation) the fees on the FFS fee schedule should be used. The FFS fee schedule can be found on the PWP under "Resources" and at Dental | HFS.
- When you bill for a service code and the CDT Code is absent from the member's plan (i.e., partials for adults) your normal UCR can be billed.

Can your office collect copayments from IL Medicaid Members?

- Providers cannot collect coinsurance, copayments, deductibles, financial penalties, or any other amount in full or part, for any service provided under their Medicaid contract.
- When a primary carrier's payment meets or exceeds the HFS Dental Program fee schedule, DentaQuest considers the claim as paid in full and no further payment is made.

What are the timely filing limitations?

- 180 days from the date of service or from the date of primary EOB.

Is prior-authorization required?

- The ORM outlines all prior-authorization and claim guidelines. Be sure to review the limitations and requirements for each procedure in the benefit grid. When required, authorizations can be submitted on the PWP, electronically, or by mail.

How do FQHCs bill encounters appropriately?

- Ensure the encounter code (D0999) is listed as your first line of service followed by the corresponding service (CDT) codes. The Clinic's normal UCR should be indicated for the corresponding service CDT codes.

Claim Tips

Avoid Delays

- Submit required documentation upfront.
    - Claims for certain services, such as those requiring pre-op X-rays and periodontal charting or detailed descriptions, must include the documentation listed in the Office Reference Manual. These documents confirm medical necessity.
- File within timely filing limits. 180 days for FFS.
- File using the appropriate member ID after verifying eligibility.
- Submit the primary EOB in its entirety when applicable.
- File using the appropriate Place of Service.
    - 03 School
    - 15 Mobile Unit
    - 50 FQHC

Treating Dentist and Billing Entity Claim Information

It is important to ensure you are billing with accurate information. Mismatches between DentaQuest and IMPACT can cause claim denials or recoupments.

- Box 48 of the ADA Dental Claim form should have the business name and address
- Box 49 of the ADA Dental Claim form should have the business NPI listed regardless if you are a large group or Sole Proprietor. Offices with subpart NPI should use the subpart NPI
- Box 51 of the ADA Dental Claim form should have the TIN that's listed for the business or SSN if they are a Sole Proprietor
- Box 54 of the ADA Dental Claim form should have the NPI for the treating dentist
- Box 55 of the ADA Dental Claim form should include the provider's license number
- Box 56 of the ADA Dental Claim form should include the provider's name and address where services were rendered

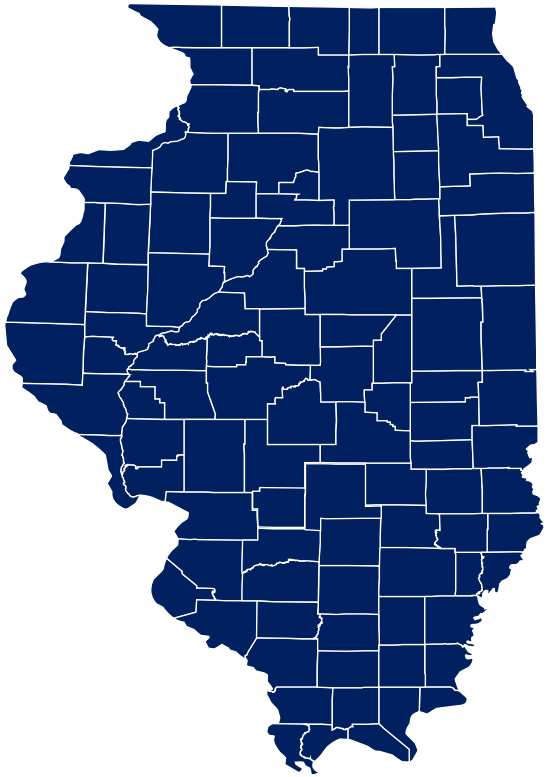
Tools and Resources

Provider Services:
888-875-7482

www.dentaquest.com

providers.dentaquest.com

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906



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Congratulations!

YOU HAVE COMPLETED THE HFS NEW PROVIDER TRAINING. PLEASE ACCESS THE SURVEY MONKEY LINK TO COMPLETE THE ATTESTATION ON THE PROVIDER WEB PORTAL UNDER "RESOURCES".

Annual Provider Training Attestation 2026 Survey

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ADDITIONAL DENTAQUEST NEW PROVIDER TRAINING

2026

DentaQuest
a Sun Life company

Illinois Medicaid Plans

Aetna Better Health, Blue Cross Blue Shield, and IL Department of Healthcare and Family Services

Group Description	Subgroup Name
IL Aetna Better Health	Aetna Better Health of IL Child NDC
	Aetna Better Health of IL Child DC
	Aetna Better Health of IL Foster Care
	Aetna Better Health of IL Pregnant Under 21
	Aetna Better Health of IL Adults DS
	Aetna Better Health of IL Adults NDA
	Aetna Better Health of IL Pregnant Over 21
Blue Cross Blue Shield of Illinois - Medicaid	Blue Cross Community FHP 0-20
	Blue Cross Community FHP 21+
	Blue Cross Community ICP 19-20
	Blue Cross Community ICP 21 & Older
IL Department of Healthcare and Family Services	HFS Medicaid Child
	HFS Medicaid Adult

Care Coordination

- Required by Public Act 096-1501, also known as Medicaid Reform.
- Many Medicaid members have been transitioned into Care Coordination programs also known as Managed Care Organizations (MCOs).
- If after 90 days they have not chosen an MCO, they are auto enrolled.

Illinois Medicaid Eligibility

Medicaid ID Numbers

- Members have unique ID numbers given to them by the health plan.
- Blue Cross Blue Shield assigns their own unique ID numbers.
- **MEDI** will contain the State issued member ID number.
- Utilize one of the options below to obtain the BCBS unique ID number
    - Ask the member to follow-up with their plan to confirm their new ID
    - Search by member name and date of birth on the Provider Web Portal (PWP) Member Eligibility screen
- Claims must contain the correct member ID number to process in the DentaQuest system.
    - Blue Cross Blue Shield: member ID 000XXX

Medicaid Eligibility

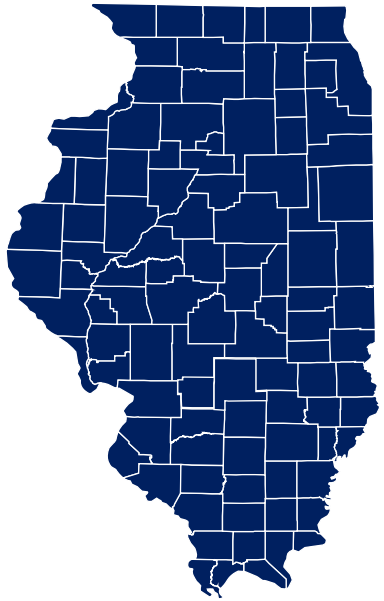
- Eligibility must be verified prior to the patient's appointment. It is advised this is done on the same day of the appointment in the event of loss of coverage or plan changes.
- Eligibility for Medicaid members should be verified using:
    - Medi (Medical Electronic Data Interchange), the State of Illinois enrollment verifications system.
    - Or by calling - Automated Voice Response System (AVRS) 1.800.842.1461.
- Why is this important? Depending on a member's circumstances, members may be enrolled in a different plan at the time of their recall or their treatment plan follow-up visit. Not every member will be administered by DentaQuest.
- Member must be eligible on the date of service.
- PLEASE DO NOT RELY ON THE ELIGIBILITY NOTED ON THE DENTAQUEST PROVIDER PORTAL. MEDI IS YOUR ELIGIBILITY SOURCE OF TRUTH

Illinois DSNP Plans (Dual Eligible Special Needs Plan)

- Humana Health Plan of Illinois and Aetna Better Health transitioned the MMAI plans to DSNP plans effective 1/1/2026.
- These plans require credentialing to NCQA standards with DentaQuest and enrollment with IMPACT as an IL Medicaid provider.
- These plans follow the Medicare Advantage fee schedule.
- These plans have an annual maximum for Medicare services.
- Medicaid services do not apply to the annual maximum.
- Most services are covered at 100%.
- Please reference the Office Reference Manual for all benefit details and limitations.

Illinois Commercial Exchange Plans

Illinois Commercial Exchange Dental Plan Features



- In and Out of Network benefits
- Member cost share
- Waiting periods & Benefit details are in the Marketplace DentaTrust Office Reference Manual

DentaTrust/IL Commercial HIX

Group Name	Subgroup Name
DentaTrust (IL HIX)	Individual Family High
	Individual Family Low
	Individual Pediatric High
	Individual Family Preventative

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Office Reference Manual (ORM)

- Is your reference to all plan related information.
- All manuals can be accessed through the Provider Web Portal (PWP) under “Resources” at providers.dentaquest.com.
- ORMs have a Table of Contents to help you quickly reference your question.
- ORMs have Exhibits that describe which benefits are covered under each plan.
- Each Exhibit will illustrate: Codes/Description/Teeth Covered/Authorization required/Benefit Limitations/Documentation Required.
- Online manuals are living documents. Updates will occur in the manual as they occur.
- It is important to use the manual on the PWP, rather than print a manual, so that you don’t miss updates.
- Ensure every team member has access to the ORMs and understands how to utilize the document.

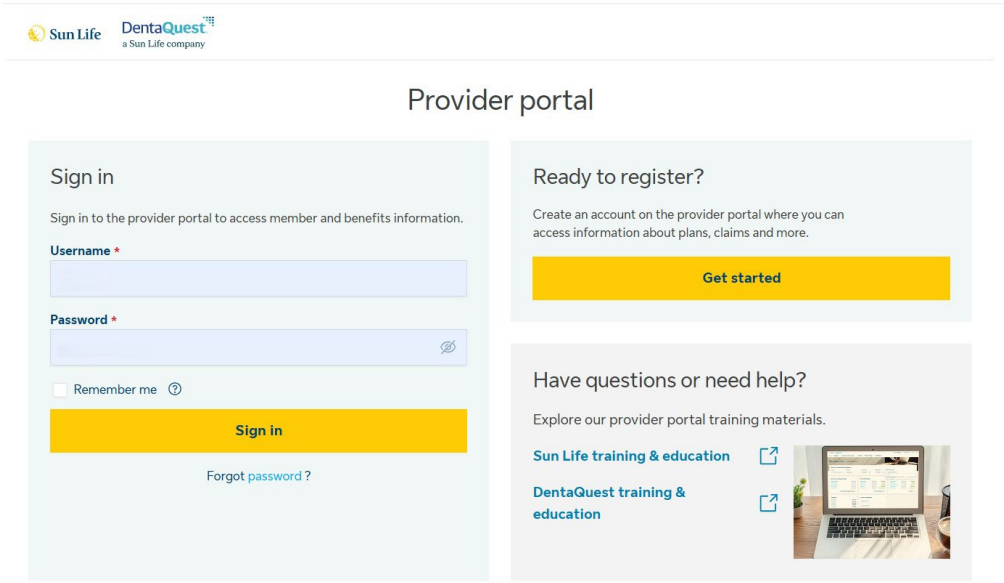
Provider Web Portal

Features

- Real Time Coverage Estimates
- Easy Access to Member Information
- Faster Member and Eligibility Search
- Submit Claims and Prior Authorizations
- Obtain EOBs

Registration is Simple

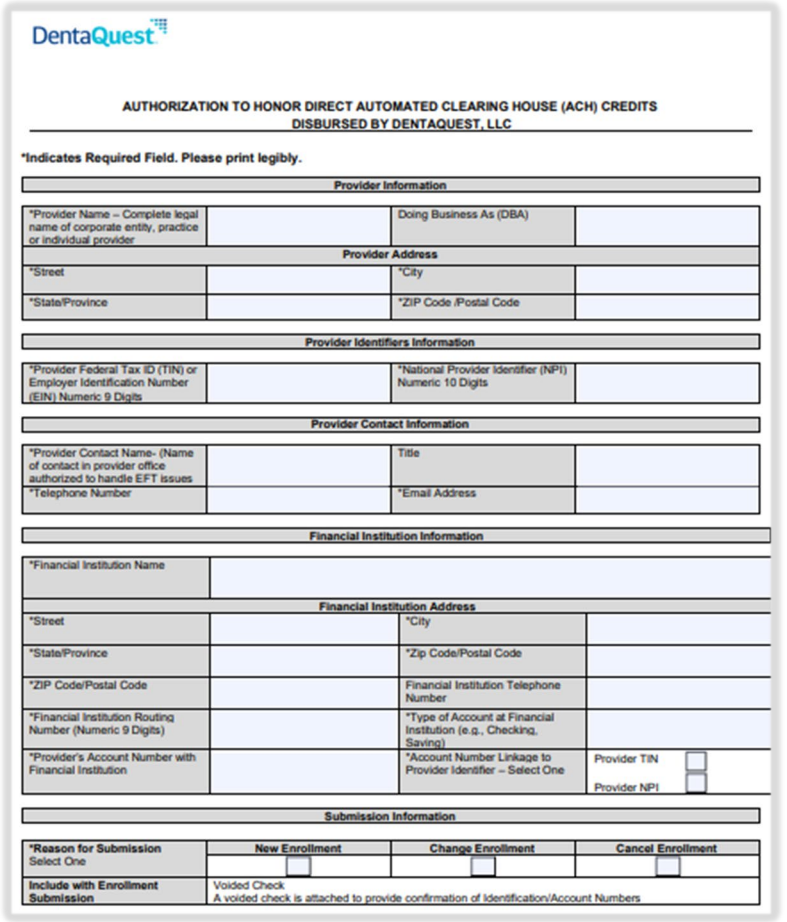
- **Go to providers.dentaquest.com/onboarding/start/ and click “Get Started”.**
- **Register as the Administrator, Office Staff, or Third-Party Administrator.**
- **Verify your email to setup your password TIN access.**



Payments Made Easy

Go Green and Elect EFT Payments

- Applications can be obtained at Update your information | DentaQuest. Please contact your Provider Partner if you require additional assistance.
- Don’t forget to include a voided check.
- Submit the completed EFT application to StandardUpdates@greatdentalplans.com or by fax to 262-241-4077.



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

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Claim and Prior Authorization Submission

Prior Authorizations

- Direct entry on the web
- Via Clearinghouse: Payer ID CX014
- By Fax: 262-241-7150
- Paper Authorizations can be sent by mail to:

  DentaQuest of Illinois, LLC
  Prior Authorizations
  PO Box 2906
  Milwaukee, WI 53201-2906

Claims

- Direct entry on the web
- Via Clearinghouse: Payer ID CX014
- By Fax: 262-241-7379
- Paper Claims can be sent by mail to:

  DentaQuest of Illinois, LLC
  Claims
  PO Box 2906
  Milwaukee, WI 53201-2906

Authorization Tips

Duplicate Authorization Submission

If a service, you are rendering requires authorization and your initial submission has been denied DO NOT continuously resubmit the auth. As noted on the Provider Determination notice, you have 60 days from the denial to appeal. You should utilize this option if you are disputing the denial, or if by chance, you need to provide additional information, i.e., additional narrative, supporting documentation, or forgotten x-rays.

Processing policy “Service not Reviewed”

This processing policy means the service/code is reviewed retrospectively (after the claim is submitted). The ORM details the clinical criteria. The plans’ stance is the provider is to couple their clinical expertise and the criteria to determine if the member qualifies for the service. Ensure that all supporting documentation is included in the claim submission to support medical necessity.

Claim Tips

Avoid Delays

- Submit required documentation upfront.
    - Claims for certain services, such as those requiring pre-op X-rays and periodontal charting or detailed descriptions, must include the documentation listed in the Office Reference Manual. These documents confirm medical necessity.
- Always review the Office Reference Manual before submitting claims to ensure all required documentation is included.
- File within timely filing limits. 180 days for Medicaid and 365 days for Medicare.
- File using the appropriate member ID and place of service.
- Submit the primary EOB in its entirety when applicable.

Treating Dentist and Billing Entity Claim Information

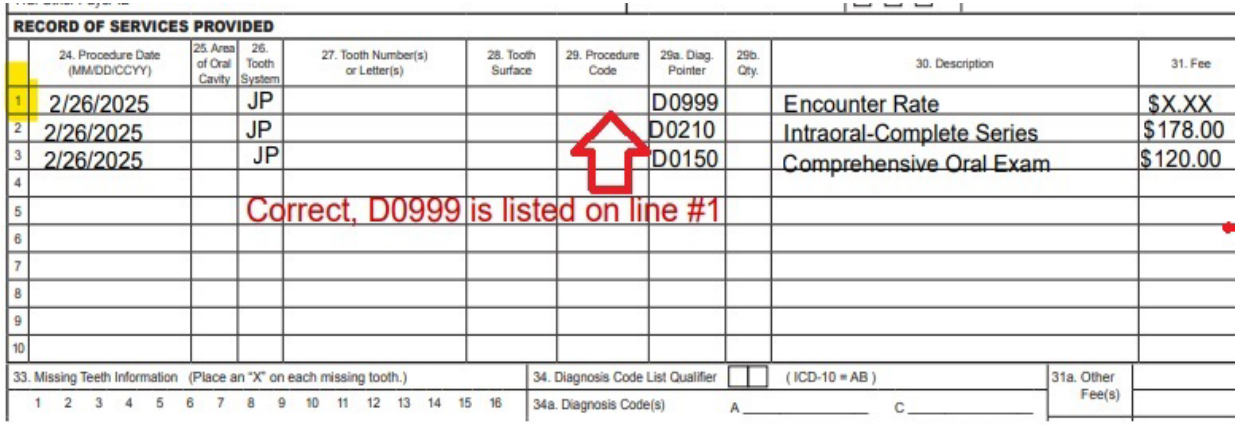
It is important to ensure you are billing with accurate information. Mismatches between DentaQuest and IMPACT can cause claim denials or recoupments.

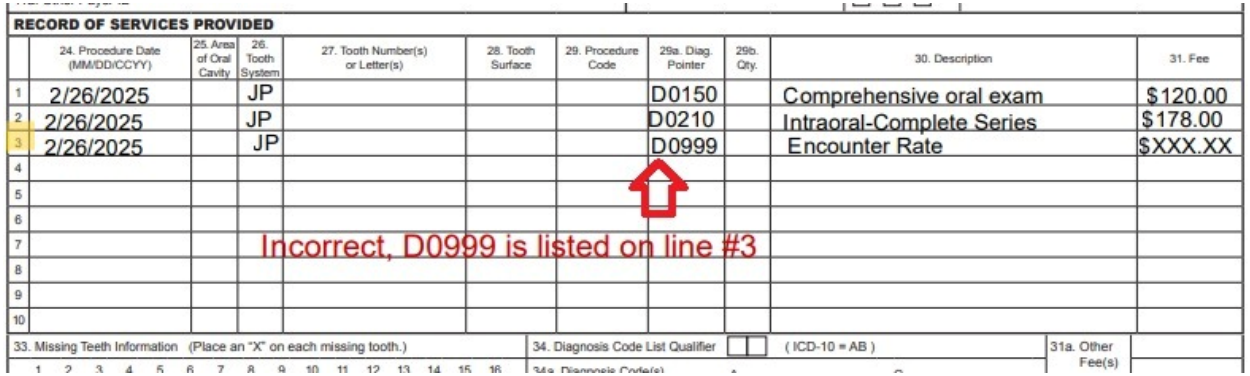
- Box 48 should have the business name and address
- Box 49 should have the business NPI listed regardless if you are a large group or Sole Proprietor. Offices with subpart NPI should use the subpart NPI
- Box 51 should have the TIN that's listed for the business or SSN if they are a Sole Proprietor
- Box 54 should have the NPI for the treating dentist
- Box 55 should include the provider's license number
- Box 56 should include the provider's name and address where services were rendered

Federally Qualified Health Centers

Proper Billing for FQHCs

- When submitting claims for rendered services, it is important to bill the encounter code (D0999) as your first service line with the appropriate encounter rate.
- Claims that are submitted without the encounter code (D0999) indicated on line 1 or billed with the corresponding service (CDT) codes as $0, will not be reimbursed.
- Please note your Clinic's normal UCR for the corresponding service (CDT) codes.





Peer-to-Peer Requests

What is a Peer to Peer?

- A Peer-to-Peer is a meeting via telephone between a participating provider and a DentaQuest Dental Director.
- The intent of the Peer to Peer is to review edits, policies, procedures, and denial codes.
- The participating provider will have the opportunity to ask questions and gain clarity.
- The Peer-to-Peer is not an appeal process, and no claims/authorizations will be overturned on a Peer-to-Peer.
- The claim/authorization is used as reference for the discussion only.

How to Make a Peer-to-Peer Request

- Make the request on the DentaQuest PWP
- Do not submit the request prior to 48 hours of the date/time requested for the call
- What to include in the request:
  - Caller name
  - Provider name
  - Reason for call: Peer to Peer Request
  - Authorization/Claim number
  - Contact phone number for provider
  - Time zone
  - Time of day provider is available to receive the call

IL Access and Availability Standards

To ensure that all members can access services in a timely manner for their dental needs, we ask our Dental Providers to work within the required appointment 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.

Dental Home

What are the benefits of Dental Home?

- Consistent place to receive care
- Comprehensive oral health care, including:
  - Individualized preventive dental health plan.
  - Assessment for oral diseases.
  - Plan for acute dental trauma.
- Referrals to dental specialists to support continuity of care.

How are members assigned to a Dental Home?

When determining where to assign a member, the following factors are considered:

- Member has a history at an identified Dental Home
- Member has a sibling currently assigned to a Dental Home
- Distance from the member's home to the Dental Home
- Member's age in relation to the ages the dental office treats
- Available capacity of the Dental Home location

Members can change their Dental Home assignment by:

- Calling DentaQuest Customer Service 1-888-875-7482
- Accessing the DentaQuest Member Portal
- Submission of a claim will also reassign the member's Dental Home to your office

Dental Home Rosters are available on the Provider Web Portal by selecting "Panel Roster" under the "Member" tab.

Annual Training Requirements

Annually each office must complete the following training courses:

- Cultural Competency & General Compliance
- Fraud, Waste & Abuse
- Annual DentaQuest Provider Training

Courses can be accessed at:
https://www.dentaquest.com/en/providers/illinois

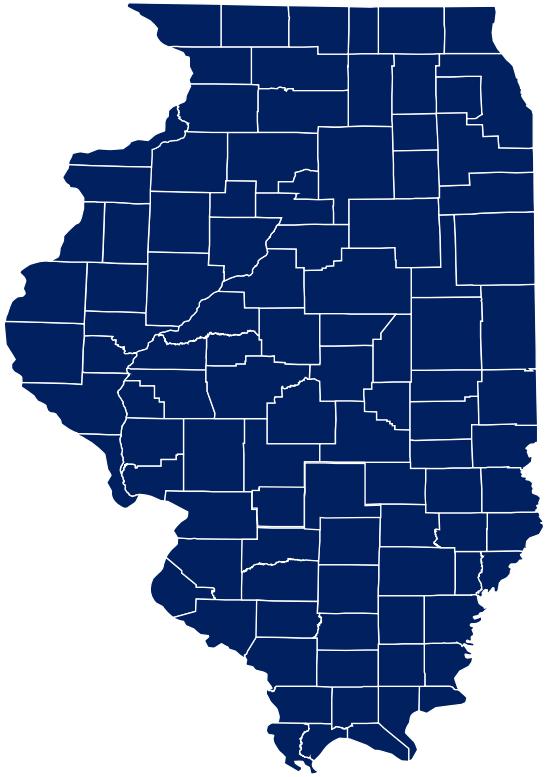
Frequently Asked Questions

- **What are the timely filing limitations?**
  - Medicaid: 180 days from the date of service or from the date of primary EOB.
  - Medicare: 365 days from the date of service or from the date of primary EOB.
  - Commercial: 365 days from the date of service or from the date of primary EOB**.**

- **What is the date of service for a permanent prosthetic?**
  - The dos for a crown, bridge, implant, or denture is the day of delivery, not on the date the procedure is started.

- **Where can I file an appeal?**
  - Appeals can be filed on the PWP.

- **Where do I find plan fee schedules?**
  - All fee schedules are located on the PWP.



Frequently Asked Questions

Can I bill a member for non-covered service?

- A non-covered service is defined a service is that is not included in the customer's benefit package
- Customers must have prior knowledge that the service is a non-covered service
- Providers may enter into a financial agreement with a customer for a non-covered service prior to rendering treatment.
- Non-covered service agreement must be completed and signed by the customer or customer's guardian prior to rendering treatment.
- The non-covered agreement must include the financial responsibility of the customer and the service(s) being rendered.

What fee can I charge for a non-covered service?

- When you bill for a service code that is non-covered and the service code is noted on the member's plan (i.e. denied for frequency limitation) the fees on the Medicaid/Medicare fee schedule should be used.
- When you bill for a service code and the CDT Code is absent from the member's plan (i.e., partials for adults) your normal UCR can be billed.

Can your office collect copayments from IL Medicaid Members?

- No deductibles or copayments are permitted for Medicaid covered services even if there are copays or deductibles associated with a member's primary insurance.
- Providers cannot collect coinsurance, copayments, deductibles, financial penalties, or any other amount in full or part, for any service provided under their Medicaid contract.
- When a primary carrier's payment meets or exceeds the Medicaid fee schedule, DentaQuest considers the claim as paid in full and no further payment is made.

Key Things to Remember

Make sure your office information is up to date.

- If you need to make updates to your office information or add plans for which you would like to treat members, please utilize the Standard Update Request Form found at Update your information | DentaQuest.
- Out of date information will result in inaccurate information in the provider search tool used by customers.

Each provider is responsible for notifying IMPACT of any demographic or status changes.

- It is important to provide your personal email address as well as your office email address to ensure all communications are received. This is especially important for revalidation.
- Failure to provide Illinois Medical Assistance with changes to the email address or physical address provided in the executed enrollment agreement will constitute waiver of service of Illinois Medical Assistance notifications and documents.

Each provider is contractually required to notify DentaQuest 60 days prior to termination.

- Ensure that the Standard Update Form is submitted 60 days prior with the effective date as the 60th day from the notice.

For immediate assistance on any DentaQuest plan related matters, contact our customer service line at: 888-281-2076

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Critical Incidents and Member Rights

Critical Incidents – Abuse, Neglect, Exploitation (ANE)

Please review the full guidelines on pages 5-9 of the Office Reference Manual. After reviewing, you must submit an attestation confirming you've read and understand the material, as attestation is required.

The Office Reference Manual can be found on the provider web portal under "resources".

Resources | DentaQuest

Additional information can be found at:

IDHS: Critical Incident Reporting Analysis System (CIRAS) Information

IDHS: Critical Incident Reporting Analysis System (CIRAS)

Member Rights and Responsibilities

Please review the full guidelines on page 3 of the Office Reference Manual. After reviewing, you must submit an attestation confirming you've read and understand the material, as attestation is required.

The Office Reference Manual can be found on the provider web portal under "resources".

Resources | DentaQuest

Attestation is required!

Please follow the link below or on the provider web portal under "resources" once you have completed review of the material.

Annual Provider Training Attestation 2026 Survey

False Claims Act (FCA)

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. Liability occurs when an individual:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

See 31 United States Code (USC) Sections 3729–3733.

Whistleblower Protection

DentaQuest protects individuals who make good faith reports of potential instances of Non-Compliance or FWA. Federal and State “whistleblower” protection laws ensure that persons who expose information or activity that is deemed illegal, dishonest, or violates professional or clinical standards will not be retaliated against.

Whistleblowers are:

- Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent of the money collected.

Health Insurance Portability and Accountability Act

Requirements

- Dentists must ensure that patient health information (PHI) is properly safeguarded. This means implementing physical, administrative, and technical safeguards to protect patient records and communications.
- Dental offices are required to establish a set of security measures designed to protect electronic PHI (ePHI).
- Dentists must utilize standardized electronic transactions for billing and record-keeping.
- All dental office staff must receive training on HIPAA regulations and best practices.
- In the event of a breach involving unsecured PHI, dentists must follow the correct procedures for notifying affected individuals and relevant authorities within the required timeframe.

HIPAA Guidelines for the Dental Office to remain compliant

- **Dental Offices*:*** Must secure Protected Health Information (PHI), which includes any oral or written information related to an individual's health condition.
- **Compliance Officer:** Dental practices should appoint an officer responsible for overseeing HIPAA compliance within the office.
- **Risk Assessments:** Regular evaluations should be conducted to identify any potential vulnerabilities.
- **Business Associates:** Those who have access to patient information through the dental office must also comply with HIPAA regulations.
- **Communication:** Policies must be in place that dictate how PHI is communicated within the office and to external parties, such as family members or insurance providers.

Tools and Resources

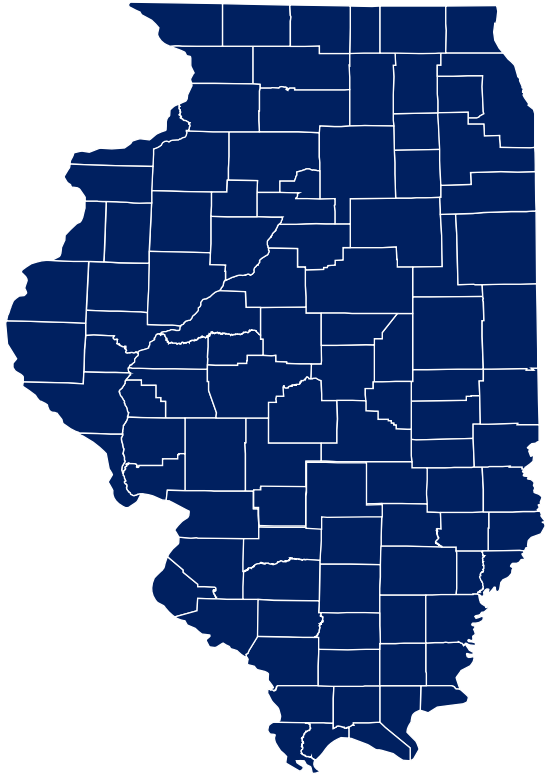
Provider Services:

800-508-6780

www.dentaquest.com

providers.dentaquest.com

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906



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Northwest, Central and Southern IL

Sun Life DentaQuest

Congratulations!

YOU HAVE COMPLETED THE DENTAQUEST NEW PROVIDER TRAINING. PLEASE ACCESS THE SURVEY MONKEY LINK TO COMPLETE THE ATTESTATION ON THE PROVIDER WEB PORTAL UNDER "RESOURCES".

Annual Provider Training Attestation 2026 Survey