DentaQuest, LLC

Office Reference Manual (ORM)

Humana Healthy Horizons in Indiana

Indiana PathWays for Aging

PO Box 2906
Milwaukee, WI 53201-2906
[855-453-5286]
www.DentaQuest.com

DentaQuest, LLC
Address and Telephone Numbers

Provider Services (including translation services)
[855-453-5286]
PO Box 2906, Milwaukee, WI 53201-2906

Member Services

Humana Healthy Horizons in Indiana / Indiana PathWays for Aging [866-274-5888]
Customer Service/Member Services
PO Box 2906, Milwaukee, WI 53201-2906

Hearing Impaired/TTY
[800-466-7566]

Fraud Hotline
[800-237-9139]

Credentialing
[800-233-1468]
PO Box 2906, Milwaukee, WI 53201-2906

Authorizations should be sent to
DENTAQUEST of IN–Authorizations
PO Box 2906, Milwaukee, WI 53201-2906

Claims should be sent to
DENTAQUEST of IN–Claims
PO Box 2906, Milwaukee, WI 53201-2906

Electronic Claims should be sent to
www.DentaQuest.com

Electronic Claims Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
PO Box 2906,
Milwaukee, WI 53201-2906

Claims Questions
[denclaims@DentaQuest.com]

Eligibility or Benefit Questions
[denelig.benefits@DentaQuest.com]

DentaQuest, LLC

Statement of Member Rights and Responsibilities

DentaQuest is committed to ensuring that all members are treated in a manner that respects their rights and acknowledges its expectations of member responsibilities.

The following is a statement of Member Rights:

- The right to be treated with respect and with due consideration for your dignity and privacy.
- The right to be furnished health care services in accordance with the applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.206 through §438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand in accordance with the applicable sections of Chapter of the Code of Federal Regulations. See 42 CFR §438.10.
- The right to have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- The right to participate with practitioners in decisions regarding your health care, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- The right to request and receive a copy of your medical records, and request they be amended or corrected as allowed in federal healthcare privacy regulations.
- The right to voice complaints, grievances or appeals about the organization or the care it provides.
- The right to make recommendations about our Member Rights and Responsibilities policy.
- The right to have an on-going source of primary care appropriate to your needs and a person formally designated as primarily responsible for coordinating your healthcare services.
- The right to receive personalized help from DentaQuest staff to ensure you are getting the care needed, especially in cases where you or your child have “special healthcare needs” such as long-term disease or severe medical condition(s).
- The right to timely access to covered services.
- The right to available services 24 hours a day, seven days a week when such availability is medically necessary.
- The right to request a second opinion from a qualified provider.
- The right to receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested.

As a member, you have the responsibility to:

- Provide information (to the extent possible) needed by DentaQuest, its practitioners and other healthcare providers so they can properly care for you.
- Follow plans and instructions for care to which you have agreed with your providers.
- Follow treatment plans and instructions for care to which you have agreed with your providers.

DentaQuest, LLC

Statement of Provider Rights and Responsibilities

Providers have the right to:

1. Communicate with members regarding treatment options.

2. Recommend a course of treatment to a Pathways member, even if the course of treatment is not a covered benefit or approved by the Humana Healthy Horizons in Indiana (hereafter referred to as "Humana") and DentaQuest. If a recommended course of treatment is not covered, e.g., not approved by Humana Healthy Horizons in Indiana for PathWays or DentaQuest, the provider must notify the member if the provider intends to charge the member for such non-compensable services. The PathWays member must sign a waiver, agreeing to pay for non-covered service. Waiver must be signed by the PathWays member before each service is rendered.

3. File an appeal or complaint pursuant to the procedures of Humana Healthy Horizons in Indiana for PathWays and DentaQuest.

4. Supply accurate, relevant, factual information to a PathWays member in connection with an appeal or complaint filed by the member.

5. Object to policies, procedures, or decisions made by Humana Healthy Horizons in Indiana for PathWays or DentaQuest.

6. To be informed of the status of their credentialing or recredentialing application upon request.

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1.00 Compliance

1.01 Professional Responsibilities

Providers are required to carry out their obligations in the manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including Indiana licensing board regulations and the Indiana Health Coverage Programs (IHCP), and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1.02 Provider Participation Requirements

1.02 (a) Humana Healthy Horizons in Indiana PathWays for Aging

[Humana limits their provider network to IHCP-attested providers who are also contracted with DentaQuest. Any claims received for PathWays members from Humana providers who are not contracted with DentaQuest will be denied without review.]

Humana Healthy Horizons in Indiana limits their provider network to IHCP-attested providers. Should a member need to seek treatment from a provider that is not contracted with DentaQuest, that provider should follow the steps in section 5.00 regarding Claims submission.

2.00 Patient Eligibility Verification Procedures

2.01 Eligibility

Any person who is enrolled in Humana Healthy Horizons in Indiana (hereafter referred to as "Humana") is eligible for benefits under the plan.

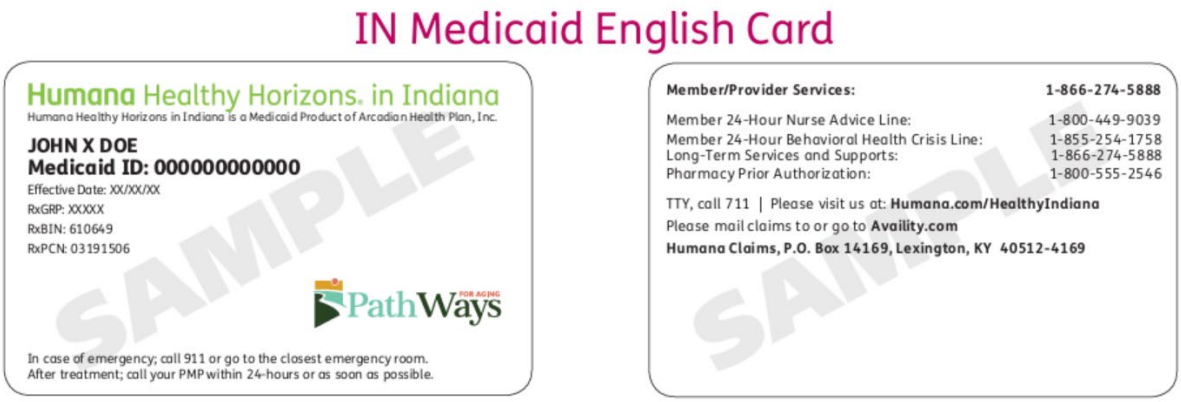
2.02 Member Identification Card

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

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change.

DentaQuest recommends that each dental office make a photocopy of the member's identification card each time treatment is provided. An identification card does not guarantee that a person is currently enrolled with Humana.

[Sample of I.D. Cards] for Humana Healthy Horizons in Indiana who are enrolled in PathWays.



Not an Official PDF

2.03 DentaQuest Eligibility Systems

Providers may access member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Provider Web Portal at https://providers.dentaquest.com/onboarding/start/. 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
Providers are encouraged to check eligibility through the IHCP eligibility check process at:

[https://portal.indianamedicaid.com/hcp/Default.aspx?alias=portal.indianamedicaid.com/hcp/provider]

The enrollment information contained within above listed web site will be considered the source of truth and should be used as the primary source of eligibility verification.

The DentaQuest Provider Web Portals allow providers to verify a member's eligibility as well as submit claims directly to DentaQuest. You can verify the member's eligibility online 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.

Directions for using the Provider Web Portals

1. Login here: https://providers.dentaquest.com/onboarding/start/
   a. First time users will have to register. To register, you will need to have information about both the business office and specific details on at least one of the Providers at that office.
2. On the left side menu of the legacy portal, select "Member Management", followed by "Member Eligibility. Enter the applicable information for each member you are inquiring about. You can check on 30 members at one time and can print off the summary of eligibility given by the system for your records.

If you have not received instruction on how to complete the Provider Self Registration or process or if you have general Provider Web Portal questions, contact DentaQuest's Customer Service Department at [855-398-8411].

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at [855-398-8411]. 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, (e.g., member history) you may have. Using your telephone keypad, you can request eligibility information on a member by entering 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.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at [855-453-5286.] They will be able to assist you in utilizing either system.

2.04 State Eligibility System

State Division of Family Resources
[800-403-0864]

Available Monday-Friday
8 a.m – 4:30 p.m. (local time)

2.05 Humana Eligibility Phone Number

Humana Member Services for PathWays: [866-274-5888]

Available Monday-Friday
8 a.m – 8 p.m. (EST)

Specialist Referral Process

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

3.00 Authorization for Treatment

3.01 Dental Treatment Requiring Prior Authorization

Prior authorization is a utilization tool that requires providers to submit documentation to support medical necessity of a request for service, associated with certain dental services for a member. Providers will not be paid if this documentation to support medical necessity of a request for service (appropriate pieces of documentation, such as X-rays or narratives are outlined in Exhibits A–F herein) is not provided to DentaQuest. In accordance with the applicable Dental Services Provider Agreement and applicable law, providers may in no event seek payment from members or persons acting on his or her behalf for providing covered services. Except where otherwise permitted by applicable law, this restriction will not prohibit collection of any applicable co-insurance, co-payments or deductibles from members or fees for non-covered services delivered on a fee-for-service basis to members under the terms of Humana Healthy Horizons in Indiana contract with the State (Indiana PathWays for Aging), the plan or other similar documents issued by DentaQuest or Humana. Furthermore, providers must hold DentaQuest, Humana Healthy Horizons in Indiana and the State of Indiana harmless in the event coverage is denied for failure to obtain authorization (either before or after services are rendered).

DentaQuest complies with all applicable utilization management (UM) regulations as set forth in federal and State laws, regulations, codes and guidelines, including but not limited Department of Labor regulations, Humana Healthy Horizons in Indiana contract with the State, DentaQuest's contract with Humana Healthy Horizons in Indiana and any other applicable standards required by NCQA, URAC and other such organizations. DentaQuest includes a list of services that require review prior to payment. The following information provides direction on when approval should be secured prior to rendering treatment and when it may be secured following treatment.

Utilization management decision making is based on appropriate care and service, and does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization. DentaQuest does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits.

3.02 DentaQuest Authorization and Prior Authorization Required Process

Authorization:

For certain codes, DentaQuest allows providers to make the decision to submit a request for authorization before or after services have been rendered to the member.

Providers have the choice to:

1. Request an authorization for approval prior to rendering treatment to a member. Obtaining an authorization before treatment assures clinical criteria is met and assists in claims adjudication for eligible members, for eligible services.

2. In lieu of obtaining an authorization in advance of providing the service, providers have the option to submit a claim with required documentation (outlined in the "Required Documentation, Exhibit A-F), after treatment has been rendered. The provider must submit required documentation. If medical necessity criteria are met and the member meets administrative requirements (such as eligibility, age, properly completed claim, etc.), the claim will be paid. This process allows the provider the ability to treat patients without having to obtain prior approval before rendering services. Claims being reviewed as an authorization must meet the same clinical criteria as a prior authorization and there is no guarantee of payment if there is not a prior authorization on file.

How to determine which codes have an authorization available?

The tables of Covered Services (Exhibits A–H) contain a column marked "Authorization Required." A "Yes" in this column indicates that the service listed requires documentation to be considered for reimbursement. All documentation needs to be submitted with the request for authorization before the treatment or with the claim submission (options 1 and 2, above).

Benefits to Authorization:

- Providers can receive an authorization before treatment, assuring those clinical criteria is met and assists in claims adjudication for eligible members, for eligible services (option 1).
- Members may receive services and providers can render services immediately (option 2).
- No submission/waiting time (option 2).

If a provider elects to submit for authorization (#1, above), documentation should include:

1. Radiographs, narrative, or other information where requested (See Exhibit A-F for specifics by code), and
2. ADA approved claim form with CDT codes on the claim form.

After DentaQuest reviews the documentation, the submitting office shall be provided an authorization number. Note that any authorizations that are denied will have been reviewed by both a DentaQuest Clinical Review Specialist and a DentaQuest Dental Consultant who is a licensed dentist. The authorization number will be provided within two business days from the date complete 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.

How to determine which codes have a required authorization?
The tables of Covered Services (Exhibits A–F) contain a column marked "Authorization Required." If this column indicates "Prior Authorization Required," documentation is required prior to treatment.

When a provider submits for required prior authorization, documentation should include:

1. Radiographs, narrative, or other information where requested (See Exhibit A-F for specifics by code), and
2. ADA approved claim form with CDT codes on the claim form.

After DentaQuest 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.

Dental Emergency – No Authorization Needed

In cases where the member has a dental emergency, the provider should perform the necessary services and submit a claim to DentaQuest with either the word EMERGENCY or the word URGENT in box 35 of the claim form. Appropriate documentation should also be included with the submission. Please see 3.02 B, below for additional details.

A. Submitting Authorization Requests and X-Rays

- Electronic submission using the Provider Web Portal.

- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit http://www.nea-fast.com and read the FAQ at the bottom of the page. To register, click the "Register" button at the top of the home page.
- Submission of duplicate radiographs is encouraged. Duplicate radiographs will be recycled and will not be returned.
- 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 request for authorization, prior authorization required 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.

B. Emergency Treatment: Authorization and documentation submitted with claim

Emergency treatment does not require prior authorization. In an emergency, the member should be treated first, and the claim should be submitted after the service, with the required documentation listed in Exhibits A–F, under the column "Required Documentation." The claim submission process for emergency services mirrors the claim process for standard claim submission. DentaQuest will review all documentation along with the claim, with the understanding that the service was performed as an emergency service and prior authorization was not required.

3.03 Payment for Non-Covered Services

Providers shall hold members, DentaQuest, Humana Healthy Horizons in Indiana PathWays for Aging and the state of Indiana harmless for the payment of non-covered services.

Members may be charged for non-covered services provided and only when the following conditions are met. DentaQuest has modeled this section after IHCP Policy which is available at the below link and is also summarized below:

https://www.in.gov/medicaid/files/provider%20enrollment.pdf

Federal and state regulations prohibit providers from charging any Indiana Health Coverage Programs (IHCP) member, or the family of a member, for any amount not paid for covered services following a reimbursement determination by the IHCP. See Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15; Indiana Administrative Code, Title 405, Article 1, Rule 1, Section 3(i). Furthermore, the IHCP Provider Agreement contains the following provision:

"To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with the federal and state statutes and regulations as the appropriate payment for Indiana Health Coverage Program covered services provided to Indiana Health Coverage Program members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Indiana Health Coverage Program covered services, excluding any co-payment permitted by law."

As a condition of the provider's participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider's recourse is limited to an adjustment request, administrative review, and appeal as provided in *405 IAC 1-1-3*. Violation of this section constitutes grounds for the termination of the Provider Agreement and decertification of the provider, at the option of the FSSA.

Charging for Missed Appointments
Medicaid accepting providers are not permitted to charge Medicaid members in accordance with federal regulations for missed appointments.

Charging for Copies or Transfers of Medical Records
Medicaid accepting providers are not permitted per federal regulations to charge for copies or transfers of medical records, including mailing costs.

Member Billing Exceptions
An IHCP provider can bill a member for **non-covered** services if a signed waiver is obtained prior to rendering services. The provider can bill for services only when the following condition is met:

- The member must understand, before receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges. The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. A provider must use a "waiver" form to document such notification. A signed written or electronic waiver must be completed by the PathWays member prior to each specific service rendered that documents the member's consent accepting responsibility for any fees.

  Note: If a waiver is used to document that a member has been informed that a service is not covered, the waiver must not include conditional language such as "if the service is not covered by the IHCP, or not authorized by the member's primary medical provider (PMP), then the member is responsible for payment." This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or prior authorization (PA) as needed.

Example of a covered service that the member may be charged for:

- The ADA code is covered by Humana Healthy Horizons in Indiana; however, it is not covered within the member's benefit package. For example, the member requests anesthesia for an extraction. Anesthesia is an allowable fee; however, the member does not meet medical criteria. Because the code is covered within the PathWays plan, the provider can bill the member the PathWays fee only, not the provider's standard and customary fee.
- To bill a member for a covered service, the provider must:

- Obtain a waiver, signed by the member, that expressly states that the service is covered in their PathWays plan only when medical necessity criteria has been established, that the member does not meet the criteria of Indiana Medicaid, their health plan or DentaQuest.
- By signing the waiver, the member is agreeing to accept any financial responsibility for covered services for which their dental case did not meet established medical necessity criteria.
- The waiver must include the amount to be charged for the non- covered services and must be signed by the member.
- A waiver signed before a service is denied by DentaQuest shall not be sufficient.

Example of a non-covered service for which the member may be charged:

- Cosmetic procedures, such as tooth whitening, are not covered benefits under any PathWays plan. The entire charge for tooth whitening is not covered by the Covered Services Rule and the provider can bill member its usual and customary fees for this service.
- If the provider is notified of the member's Medicaid eligibility within the one-year filing limit, the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the member must be reimbursed in full to the IHCP member.
- Documentation must be maintained in the file to establish that the member was billed or information requested within the filing limit.
- Providers may bill a member if the service is not covered by the member's benefit plan,
- Providers may bill a member when a covered service required authorization and was denied by DentaQuest. If the member would like to proceed with the treatment, the provider must:
  - Obtain a waiver, signed by the member, that expressly states that the service is covered in their PathWays plan only when medical necessity criteria has been established, that the member does not meet the criteria of Indiana Medicaid, their health plan or DentaQuest.
  - By signing the wavier, the member is agreeing to accept any financial responsibility for covered services for which their dental case did not meet established medical necessity criteria.
  - The wavier must include the amount to be charged for the non- covered services and must be signed by the member.
  - A waiver signed before a service is denied by DentaQuest shall not be sufficient.
- Providers may not bill a member when they submit a claim after the service was rendered, without authorization and the claim is denied. Because the service was rendered, you cannot go back and bill the member because the claim was denied, and the member was not given the chance to sign a waiver that included the above criteria.

Refusing or Restricting Services to Members

A provider can decide not to provide a service to a member as long as the reason for doing so is not a violation of civil rights laws or the *Americans with Disabilities Act* and abides by state and Federal laws.

Policies and patient care must be the same for Medicaid, commercial or fee for services patients. For example, Medicaid participating providers cannot prioritize commercial members over Medicaid patients. For example, Medicaid members should not be made to wait in the waiting room for services while commercial members are given priority appointments.

Providers can restrict the number of IHCP patients by any means, if their standards for limiting patients do not violate any statutes or regulations.

For example, *405 IAC 5-1-2* prohibits discrimination on the basis of "age, race, creed, color, national origin, sex, or handicap." If the provider's specialty is limited to patients of a certain age or sex, such as gynecology or pediatrics, that is permissible. If individual providers are unsure whether their standards or methods violate civil rights laws or any other laws, they must verify with their attorneys.

3.04 Electronic Attachments

DentaQuest accepts dental radiographs electronically via FastAttach™ for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows 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, authorization and/or prior authorization required processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at 800-782-5150

3.05 Dispute Resolution/Provider Appeals Procedure

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

[All prior authorization appeals must be filed to the member's Humana at the appropriate address listed below:

Humana Healthy Horizons in Indiana
Humana Customer Service Department
Healthy Horizons in Indiana
Attn: Appeals or Arbitration
201 North Illinois Street Suite 1200
Indianapolis, IN 46204

The term "appeal" is defined as a request for review of an action. An "action," as defined in applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined the state; or
- Failure of Humana to act within the required timeframes.

Member Appeals

Members may file the appeal orally or in writing. Authorized representatives or providers may act on behalf of members with respect to requesting an appeal and the procedures involved. The member is allowed the opportunity for representation by anyone he or she chooses, including a provider or attorney. For appeals, a health care practitioner with knowledge of the member's

condition (e.g., the treating practitioner) may act as the member's authorized representative. The member and member representative may present evidence or testimony in person as well as in writing.

Standard Appeals: Humana must acknowledge receipt of each standard appeal within three (3) business days. Humana must decide on standard, non-expedited, appeals within thirty (30) calendar days of receipt of the appeal. per 42 CFR 438.408(a) and 42 CFR 438.408(b)(2). This timeframe may be extended up to fourteen (14) calendar days, if the member requests the extension, or if Humana shows that there is need for additional information and that delay is in the member's interest (upon State request), pursuant to 42 CFR 438.408(c). If) (1) and 42 CFR 438.408(b)(2). In accordance with 42 CFR 438.408(c)(2) and 42 CFR 438.408(b), if the timeframe is extended, for any extension not requested by the member, Humana must make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice, within two (2) calendar days, and include the reason for the decision and inform the member of their right to file a grievance if he or she disagrees with that decision of the reason for the delay.

- Expedited appeals: The member's Humana resolves expedited appeals meeting FSSA criteria within 48 hours of receiving the request and the [provider and member are notified immediately by telephone. This time frame can be extended pursuant to the applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.408(c). A written confirmation of the decision is also sent by mail to the member within 48 hours of notification., in additional to the phone call explaining the outcome of the expedited appeal.

Levels of Further Appeal

If the member is not satisfied with appeal decision, or if the standard appeal or expedited appeal results in upholding the denial, additional external appeal procedure options are available to the member. The member (or member's representative or the provider on the member's behalf) may choose either an external review by an Independent Review Organization (IRO) or a State fair hearing. The IRO process may run concurrently with a State Fair Hearing.

External Review

- Independent Review Organization (IRO): A member may pursue review by an IRO if they are not satisfied with the member's Humana appeal decision (must be filed within 120 calendar days of receiving appeal determination). The IRO is available for appeals that involve an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. A member may also pursue an expedited external review. Requests for excluded benefits or exceed benefits are not eligible for independent review.

- Within one hundred and twenty (120) calendar days from the date of Humana's decision on the member's appeal, a member, or a member's representative may file a written request for a review of the Contractor's decision by an independent review organization (IRO). The IRO shall render a decision to uphold or reverse the Contractor's decision within seventy-two (72) hours for an expedited appeal, or fifteen (15) business days for a standard appeal. The determination made by the independent review organization is binding on the Contractor. IRO clinicians do not have to be Indiana licensed.
- .
    - The member is informed that he/she is not required to bear costs of the IRO, including any filing fees. An IRO determination is binding.
    - The resolution notification of an IRO denial decision includes the member's appeal rights to request a FSSA fair hearing.

State Fair Hearing

PathWays members must exhaust the Humana Healthy Horizons in Indiana grievance and appeals process before requesting a State Fair Hearing. The member may choose to request the State fair hearing by submitting a written request directly to FSSA within 120 calendar days of exhausting the Humana grievance and appeals process.

Members submit a request directly to FSSA for a State fair hearing and timeframes are according to those rules that govern the FSSA in conducting the State fair hearing. Humana Healthy Horizons responds to all information requests by the FSSA fair hearing officer or designee within the required format and timeframe.

All notices of actions with appeal rights and notices of final action by Humana where the next course of action is a State fair hearing shall have the following language included:

"This is an administrative action by the State of Indiana. If you disagree with this decision, you can appeal it. Appeals are handled by the State of Indiana Office of Administrative Law Proceedings. You may mail your request for a State fair hearing to the State of Indiana Office of Administrative Law Proceedings at:

Office of Administrative Law Proceedings

100 N. Senate Avenue, Room N802, Indianapolis, IN 46204

Email: fssa.appeals@oalp.in.gov

Phone: 317-234-3488 or 866-259-3573 (toll free)

Fax: 317-232-4412

Please Note: At all levels of the grievance and appeal process, the member's Humana allows the member the opportunity for representation by anyone he or she chooses, including an attorney or provider.

In compliance with 42 CFR 438.408(b)-(c), the Contractor shall provide the member or representative, the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions in compliance with Indiana law and no longer than thirty (30) calendar days from the day the Contractor receives the appeal. This time period is reduced to 72 hours from the day the Contractor receives an expedited appeal.

4.00 Participating Hospitals

In the event that a provider cannot render services in their office, DentaQuest understands that the provider may need to treat members in a hospital setting due to the member's medical history. In these cases, DentaQuest will adjudicate for the dental services and the appropriate Humana will adjudicate for the hospital charges. Hospital services may require authorization from Humana Healthy Horizons in Indiana and must be performed at a hospital that contracts with the member's Humana. Upon approval, DentaQuest participating providers are required to administer services at Humana Healthy Horizons in Indiana participating hospitals. The provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, the

provider should contact the appropriate Humana below for facility authorization at the number below.

Humana Healthy Horizons in Indiana Member and Provider Services for Indiana PathWays for Aging: [866-274-5888]. This line is accessible to members and providers participating in Humana Healthy Horizons in Indiana. It is available Monday-Friday, from 8 AM – 8PM EST.

Participating Hospitals may change. Please contact Humana Healthy Horizons in Indiana for current listing.

5.00 Claim Submission Procedures (claim filing options)

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

- Electronic claims submission using the Provider Web Portal at https://govservices.dentaquest.com
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

5.01 Submitting Authorization or Claims with X-Rays

- Electronic submission using the Provider Web Portal.
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and read the FAQ at the bottom of the page. To register, click the "Register" button at the top 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 that photocopies of radiographs are rarely of diagnostic quality and should not be submitted.**

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 request for authorization or prior authorization required 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.

5.02 Electronic Claim Submission Utilizing DentaQuest's Internet Website

DentaQuest Participating providers may submit claims directly to DentaQuest by utilizing the 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. Claims submitted electronically will be reviewed and paid or denied accordingly within 21 days.

To submit claims via the Provider Web Portal:

1. Login to https://providers.dentaquest.com/onboarding/start/
2. Select "Claims/Pre-Authorizations" from the left menu and then "Submit Claims & Pre Authorizations". The Provider Web Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

5.03 Electronic Authorization Submission Utilizing DentaQuest's Internet Website

DentaQuest Participating providers may submit authorization or prior authorization required requests directly to DentaQuest by utilizing the Provider Web Portal. Submitting prior authorizations via the Provider Web Portal 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 authorization or prior authorization required requests via the Provider Web Portal:

1. Login to https://providers.dentaquest.com/onboarding/start/
2. Select "Claims & Pre-Authorizations" from the left menu and then "Submit Claims & Pre-Authorizations."

The Provider Web Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.

5.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with [Change Health Care (888-255-7293), Tesia (800-724-7240), DentalXChange (800-576-6412), Claim Remedi (800-763-8484), TriZetto (800-969-3666), InMediata (877-466-9656)] for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

5.05 HIPAA Compliant 837D File

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

5.06 National Provider Identifier (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 federal and state required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website [https://nppes.cms.hhs.gov/NPPES/Welcome.do] and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) 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 following the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

5.07 Paper Claim Submission

- Claims must be submitted on ADA-approved claim forms or other forms approved in advance by DentaQuest.

- Claims submitted on paper will be reviewed and paid or denied accordingly within 30 days.

- Member name, identification number, and date of birth must be listed on all claims submitted. If the member identification number is missing or miscoded on the claim form, the patient cannot be identified. This will result in the claim being returned to the submitting provider office, causing a delay in payment.

- The paper claim must contain a legible provider name and signature.

- The provider and office location information must be clearly identified on the claim. If only the dentist signature is used for identification, the dentist's name may not be clearly identified. Please include a typed dentist (practice) name or the DentaQuest Provider Identification Number.

- The paper claim form must contain a valid provider National Provider Identification (NPI) number.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept mail with postage due. This mail will be returned to the sender and will result in delay of payment.

  Claims should be mailed to the following address:

  DENTAQUEST of Indiana, LLC–Claims
  PO Box 2906
  Milwaukee, WI 53201-2906

5.08 Third Party Liability (TPL)

According to state and federal regulations, Medicaid, therefore DentaQuest, is the payer of last resort. When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim.

Submitting TPL Claims to DentaQuest

- Providers must include a copy of the third party's explanation of benefits when submitting a claim to DentaQuest. [At a minimum, submitted EOBs must minimally include the date of service, the services provided as identified by the appropriate ADA CDT code, and the date any payment was issued.] For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field.

- When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

- If DentaQuest has already paid the provider and subsequently the provider obtains TPL payment, the provider must submit a refund to DentaQuest.

Liability Insurance

If a provider is aware that a member has been in an accident; however, does not yet know who the liable third party is, the provider can bill DentaQuest. If DentaQuest is billed, the provider must note the claims are for accident-related services on the applicable claim form. If a provider initially pursues payment from the liable third party and the claim is submitted to DentaQuest after the filing time limit, the claim may be denied.

Third-Party Payer Fails to Respond (90-Day Provision)

When the member has other insurance, a DentaQuest provider must submit claims to the other insurance carrier before submitting to DentaQuest. When a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to DentaQuest for payment consideration. However, one of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words **no response after 90 days** on an attachment. This information must be clearly indicated with written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date.
- The provider is required to boldly make a note of the following on the attachment:
  - Date of the filing attempt
  - The phrase "no response after 90 days"
  - Member identification number (RID) & Provider's National Provider Identifier (NPI)
  - Name of primary insurance carrier billed
- For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:
  - Date of the filing attempt
  - The phrase "no response after 90 days"
  - The member's identification (RID) number & IHCP provider number
  - Name of primary insurance carrier billed

5.09 Filing Limits

Contracted providers must submit all claims within 90 days of the performance of service. Any claim submitted beyond the timely filing limit of 90 days for a DentaQuest contracted provider and [180] days for a non-contracted DentaQuest provider or emergency services 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.

5.10 Receipt and Audit of Claims

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

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

5.11 Direct Deposit

As a benefit to providers, DentaQuest offers Electronic Funds Transfer (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 that can be found on the website: https://providers.dentaquest.com/onboarding/start/
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest:

  Via Fax: [262-241-4077]

  Via Mail: DentaQuest, LLC.
  PO Box 2906
  Milwaukee, WI 53201-2906
  ATTN: PDA Department

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 two to three 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. Providers may access their remittance statements by following the below:

1. Login to https://providers.dentaquest.com/onboarding/start/
2. Select "Explanation of Benefits" from the left menu.

6.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

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

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

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

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

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at [855-398-8411] or via email at [denelig.benefits@DentaQuest.com.]

6.01 HIPAA Companion Guide

DentaQuest participating providers may view a copy of the most recent HIPPA Companion Guide by utilizing the Provider Web Portal:

1. Login to https://providers.dentaquest.com/onboarding/start/
2. Log in using your password and ID.
3. Once you have logged in, click on the link named "Document List" on the left menu.

7.00 Provider Inquiries, Complaints and Grievances (Policies 200.010, 200.011, 200.013, 200.017)

DentaQuest adheres to Indiana state, federal, and Humana requirements related to processing inquiries, complaints, and grievances. Unless otherwise required by Indiana state and Humana, DentaQuest processes such inquiries, grievances and appeals consistent with the following:

A. Inquiry: The term *inquiry* refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

B. Grievance: The term *grievance*, as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships, such as rudeness of a provider or employee or the failure to respect the member's rights. A grievance is a complaint about the way a member's health plan is giving care. For example, a member may file a grievance if the member has a problem calling the plan or if the member is unhappy with the way a staff person at the plan has behaved toward them. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see appeal).

C. Appeal: The term *appeal* is defined as a request for a review of an action. The term *appeal*, per 42 CFR §438.400, (b), is defined as a request for a review of an action. An appeal is a special kind of complaint a member may make if they disagree with a decision to deny a request for health care services or payment for services they've already received. An *action,* as defined in the applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.400(b).

D. Expedited Appeal: An expedited request for review of an action. An *Expedited Appeal* is defined as a review related to an illness, disease, condition, injury, or disability that would seriously jeopardize the member's life, health, or ability to reach and maintain maximum function.

E. DentaQuest's Complaints/Grievance Coordinator receives member and provider inquiries, grievances and appeals. The Coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified of the resolution (i.e., Humana, member, and provider as applicable). The grievance or appeal is closed and maintained on file for tracking and trending purposes. Any member and any provider acting on behalf of a member with the member's consent may appeal any utilization management determination resulting in a denial, reduction, suspension or termination of dental services.

F. DentaQuest prefers to receive provider formal grievances in writing, oral grievances are also accepted. All documentation relating to the grievance should be included with the grievance.

G. If you or the member disagrees with DentaQuest's decision concerning a pre-service request, you or the member may file an appeal in writing or verbally. You have 60 calendar days from the date of the determination to file the appeal. If you are submitting the appeal on the member's behalf, you must include the member's written permission with your request. Pre-service appeals for all MCEs should be directed to the addresses listed below (this process is outlined in section 2.05).

H. If you or the member disagrees with DentaQuest's decision concerning a post-service request, you or the member may file an appeal in writing. You have 60 calendar days

from the date of the determination to file the appeal. All post service appeals should be sent to DentaQuest at the address listed below.

l. The Complaints/Grievances Coordinator receives member and provider grievances and appeals. The Coordinator requests appropriate documentation, forwards the documentation to the dental consultant for review and determination, and the decision to uphold or overturn the initial decision is communicated to the appropriate individuals.

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at [855-453-5286.]

Inquiries, complaints and grievances for Humana Healthy Horizons in Indiana should be sent to:

Humana Healthy Horizons in Indiana

Member Complaints/Grievances/
Pre-service Appeals:

Healthy Horizons in Indiana
Attn: Appeals or Arbitration
201 North Illinois Street Suite 1200
Indianapolis, IN 46204

Appeals may be submitted in writing or by calling [866-274-5888]

Provider Complaint/Grievances:
PO Box 2906
Milwaukee, WI 53201-2906

8.00 Utilization Management Program

8.01 Introduction

DentaQuest is committed to providing cost effective, accessible and quality care to members and utilization management is an essential component. Our Utilization Management program is in place to consistently evaluate and address appropriate utilization of dental services in a cost effective and timely manner. Our Utilization Management Department works toward accurate

administration of the plan's benefits. With the effective administration of the DentaQuest policies and procedures, we can assure that Utilization Management decisions are made in a fair and consistent manner, and that members have equitable access to care.

DentaQuest complies with recognized Utilization Management regulations as they apply to dentistry including any federal or state regulations, including the Department of Labor Employee Retirement Income Security Act (ERISA) regulations, as well as standards and guidelines through such organizations as NCQA and URAC.

8.02 Community Practice Patterns

DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. 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.

8.03 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
- Treatment cost effectiveness

8.04 Fraud and Abuse

Definitions:

Fraud: In insurance fraud, "fraud" is the intentional submission of a "document or statement" that contains a material misrepresentation made by an individual/entity knowing that the document/statement contains false or misleading information for the purpose of receiving benefits to which they would not have otherwise been entitled.

Waste: Is defined as a loss through carelessness, inefficiency, or ignorance**.**

Abuse: Is considered an action that is not consistent with generally accepted standards and practices related to that industry.

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

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency. Suspected fraudulent behavior should be reported to DentaQuest.

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

Reporting Fraud:

It is the responsibility of ***everyone*** to report suspected Fraud, Waste and Abuse. The avenues for reporting are:

DentaQuest Fraud Hotline: [800-237-9139]

FSSA Fraud Hotline: [800-403-0864]

You can find more information about reporting fraud and abuse at
http://www.in.gov/fssa/2385.htm

How Does DentaQuest investigate Fraud?

DentaQuest will respond to all incoming calls alleging suspected fraud, waste or abuse to determine the validity of the allegation and will conduct in depth data analysis of paid claims to determine the proper course of action. DentaQuest will open an investigation to include a review of clinical records, if the allegations are substantiated through preliminary interviews and data analysis.

It is the policy of DentaQuest to provide service in a manner that complies with applicable federal and state laws, including but not limited to the applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §438.608 (Program Integrity Requirements) as well as the administrative and civil remedies under Chapters 32 and 36 of Title 31 and that meets the high standards of professional ethics.

It is the responsibility of the Fraud Prevention and Recovery Department under the direction of the Vice President of Fraud Prevention and Recovery and the Director of Fraud Prevention and Recovery to investigate all potential issues and/or allegations of program fraud, waste and abuse by network providers and Medicaid recipients, and comply with all contractually required reporting requirements to the Office of Medicaid Integrity. The Vice President of Fraud Prevention and Recovery serves as a liaison to the Compliance Officer with respect to the activities of the Fraud Prevention and Recovery Department including cases under investigation that may require the involvement of the Compliance Officer. The Vice President and Manager of Fraud Prevention and Recovery are members DentaQuest's Compliance Committee.

The Fraud Prevention and Recovery Unit is integral to fulfilling the DentaQuest Anti-Fraud, Waste and Abuse (FWA) Plan. The Unit's mission is to establish policies and procedures for the prevention, detection, and investigation of FWA. Through sophisticated data analysis and strong compliance and monitoring, the Fraud Prevention & Recovery Unit identifies outlier provider practice patterns, completes record reviews, and determines root causes. During investigation, the unit evaluates utilization trends and medical necessity, determines whether services were rendered as billed and accurately coded, and assures that services meet accepted professional standards of care. Based upon the results of the investigative process, appropriate corrective actions are implemented. These actions include provider education, recovery of funds, authorization or prior authorization, contract termination, and/or referrals to the client or state agency. DentaQuest is committed to the provision of "high quality and medically necessary treatment within the allocated financial resources". The Fraud Prevention and Recovery Department accomplishes this goal through compliance with DentaQuest's policies and procedures and proper management of the Fraud Prevention and Recovery program. Proper management of the program ensures that our members, clients, and/or taxpayers are protected from inappropriate use of the allocated financial

resources. DentaQuest requires that any suspicion or occurrence of fraud be reported to the plan, state or appropriate agency.

Our goals are as follows:

- Prevent fraud and abuse
- Stop fraud when it occurs
- Assist in the recovery of losses
- Assist in the apprehension and prosecution of the perpetrators
- Educate our employees, providers, clients and members to identify potential problems

Through rigorous data analysis methods, DentaQuest identifies providers whose practice patterns are outside of the norm for both over-utilization and under-utilization. DentaQuest conducts ongoing, retrospective review on a peer-to-peer comparison analysis:

- That the quality of services rendered are maintained at a high level and are in line with a practical and conservative oral health approach
- Services meet Medical Necessity Guidelines
- Reflect preventive practice patterns that increase the likelihood of improved oral health

FWA ALERT REPORT: DentaQuest has developed a three-part methodology: 1) a statistically valid methodology detecting utilization outliers among for key procedure code, code sets, ratios and payment patterns that have been demonstrated through statistical modeling, industry best-practice monitoring and our experience in network management to point to fraud, waste or abuse; 2) a predictive model applying machine learning techniques to actual results to assign each provider a fraud risk score based on dynamically adapting criteria, and 3) ongoing analyst-driven benchmarking and data mining to discover evolving behaviors and risk indicators. Outlier detection employs the Tukey method of using interquartile ranges that is also used by the Office of Inspector General (OIG) that is superior to standard deviation rules. Behavioral classification of providers focuses in on outliers better by defining provider peer groups not only by their stated specialty but also by how they behave. The scoring model is a continuing collaboration with best-in-class data mining consultants who apply similar advanced modeling techniques to homeland security and postal fraud detection. Based on the cumulative results of DentaQuest's scoring, active data mining and passive statistical tests, providers may be subject to a spectrum of remedial actions including, but not limited to, a records audit, additional pre-payment clinical review requirements and/or educational reinforcement.

DentaQuest Investigative Process for Suspected Provider Fraud, Waste and Abuse:

The Fraud Prevention and Recovery Department in compliance with the applicable sections of Chapter 42 of the Code of Federal Regulations. See 42 CFR §456, will conduct an investigation upon detection of any potential provider/member fraud, waste and abuse. DentaQuest will send a written request for member records and these records are subject to a comprehensive administrative and clinical review in order to:

- Determine the sufficiency of the records to evaluate the utilization and quality of the services for which claims have been submitted
- Assure services were medically necessary

- Assure services were rendered as billed and accurately coded following the descriptors and nomenclature of the American Dental Association Current Dental Terminology
- Assure that all services meet the accepted professional standard of care

DentaQuest Actions Based on Results of Investigative Process:

At the completion of the investigative process if findings include, but are not limited to:

- Services not rendered
- Upcoding
- Failure of documentation to meet medical necessity criteria
- Services do not meet the professionally recognized and accepted standards of care
- Violations of the Provider Agreement

DentaQuest can and will take the appropriate actions as determined by the results and findings of the investigations, these actions can include, but are not limited to:

- Provider education
- Recovery of funds
- Referral to DentaQuest Peer Review
- Corrective Action Plan
- Placement of the provider on the Utilization Oversight Program requiring authorization and/or required prior authorization of services
- Referral to the appropriate client or state agency
- Recommendation for termination from network participation

Credible Allegations of Fraud:

DentaQuest upon identification of a Credible Allegation of Fraud appropriately refers the case following all client specific contractual obligations.

9.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes, but is not limited to:

- Provider credentialing and 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
- Quarterly Quality Indicator tracking (e.g., complaint rate, appointment waiting time, access to care, etc.)

Quality of care issues are handled under the areas listed in this section:

- Random chart audit
- A component of chart audits or record reviews is to review the quality of care of services rendered
- Quality-of-care issues are referred from Complaints, Grievances & Appeals to Utilization Review for further investigation
- Complaint monitoring and trending
- Peer Review Process
- Providers identified with patterns of quality-of-care issues are reviewed by the Committee.

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at [855-453-5286] or via email at: [denelig.benefits@DentaQuest.com.]

10.00 Credentialing (Policies 300 Series)

DentaQuest, in conjunction with Humana Healthy Horizons in Indiana has the 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, corrective action 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 Humana Healthy Horizons in Indiana for PathWays.

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

DentaQuest does not have the sole ability to accept and discipline participating providers, including restricting participation by a dental office or terminating a participating provider's written agreement. Humana Healthy Horizons in Indiana has the final decision-making power regarding network participation. DentaQuest will notify Humana Healthy Horizons in Indiana of all corrective actions enacted upon participating providers. IHCP has the ultimate decision when it comes to revoking a provider's participation with Indiana Medicaid.

To contract with DentaQuest, a provider must first become an IHCP provider. To review requirements on how to become an IHCP provider, please visit:

[https://www.in.gov/medicaid/providers/451.htm]

DentaQuest's Policies and Procedures outline all credentialing details and are available by contacting our Customer Service Department at [855-453-5286 or denelig.benefits@DentaQuest.com]

- Appeal of Credentialing Committee Recommendations (Policy 300.004):
  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 business days of the date the Committee gave notice of its decision to the applicant.

- Ongoing Monitoring (Policy 300.013).

- Recredentialing (Policy 300.009):
  Network providers are recredentialed at least every 24 months.

11.00 The Member Record

Member records will be maintained in compliance with federal and state law and the provider's agreement with DentaQuest.

A. Organization

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

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

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

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

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

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

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

B. Content – the member record must contain the following:

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

   a. Member's first and last name
   b. Date of birth
   c. Sex
   d. Address
   e. Telephone number
   f. Name and telephone number of the person to contact in case of emergency

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

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

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

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

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

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

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

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

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

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

7. Radiographs which are:

a. Identified by patient name

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

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

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

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

10. 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 member's oral hygiene status and preventive efforts which requires entry of these items:

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

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

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

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

a. Date of service/procedure
b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
c. Type and dosage of anesthetics and medications given or prescribed
d. Localization of procedure/observation (tooth #, quadrant etc.)
e. Signature of the provider who rendered the service

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

a. Member examination
b. Treatment plan

c. Treatment status

C. Compliance

1. The member record has one explicitly defined format that is currently in use.

2. There is consistent use of each component of the member record by all staff.

3. The components of the record that are required for complete documentation of each member'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.

12.00 Patient Recall/ Preventative Treatment Notification System Requirements

A. Recall/ Preventative Treatment Notification System Requirement

Each participating DentaQuest office is required to maintain and document a formal system for member retreatment notification. The system can utilize either written or phone contact. Any system should encompass routine patient checkups, 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 checkups 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."

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 providers are expected to meet minimum standards with regards to appointment availability.

- Humana Healthy Horizons in Indiana for PathWays members:
  - Urgent care must be available within 24 hours.
  - Emergency care must be available within 24 hours/7 days per week.
  - Routine care must be available within 30 calendar days.

13.00 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 member.

2. Adult – edentulous

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

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 intervals of 12 months for adults with clinical caries or who are at increased risk for the development of caries.

d. Adult – edentulous

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

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

c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at intervals of 12 months for dentulous adult members 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).

14.00 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals and Indiana Medicaid's Medical Policy Manual, IHCP Bulletins and Banners, Indiana Administrative Code (IAC), and Indiana Code (IC). 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.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, and 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, you are required to review and become familiar with the "Benefits Covered" section before providing any treatment.

14.01 Criteria for Dental Extractions

Dental extractions do not require authorization.

Criteria for orthodontics extractions:

The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.

14.02 Criteria for Endodontics

Please reference the Exhibits to determine which ADA codes are covered and require authorization. Not all procedures require authorization.

Documentation needed to adjudicate a claim:

- Sufficient and appropriate radiographs, to be in the member's records, clearly showing the adjacent and opposing teeth (if present) 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 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.

14.03 Criteria for Resin and Stainless-Steel Crowns

Authorization is not required for resin and stainless-steel crowns. The following criteria apply for primary or permanent teeth:

Criteria:

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

- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.

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

- For primary teeth, evidence/necessity of pulpotomy/pulpectomy

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

- Request should include a dated post-endodontic radiograph.

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

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

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

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

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

Authorization and treatment using stainless steel crowns will not meet criteria if:

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.

- Tooth has advanced periodontal disease.

- Tooth is a primary tooth with exfoliation imminent.

- Crowns are being planned to alter vertical dimension.

14.04 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

- Treatment plan (prior-authorized, if necessary).

- Narrative describing medical necessity for OR.

Except in the case of an emergency, Operating room (OR) cases require prior authorization. For details on emergency services, please see section 3.02 B. For details on participating hospitals, please see section 4.00.

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, provider should contact Health Plan for facility authorization at the number below.

Monday-Friday 8 AM – 8PM EST

Criteria:

Operating room cases will be prior authorized (for procedures covered by Humana) if the following is (are) involved:

- In accordance with IHCP policy if one of the following admission indicators is present:
    - Mental incapacitation such that the recipient's ability to cooperate with procedures is impaired, including cognitive disability or organic brain disease with uncooperative, but otherwise healthy children
    - Severe physical disorders affecting the tongue or jaw movements
    - Seizure disorders
    - Significant psychiatric disorders resulting in impairment of the recipient's ability to cooperate with procedures
    - Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
    - The need for oral surgery, listed in 405 IAC 5-19-17; or in extreme cases of facial trauma, pathology, or deformity
    - Periodontal surgery only in cases of drug-induced periodontal hyperplasia
    - Elective oral surgery when recipient is unable to cooperate with or tolerate the procedure

- Members requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) Class III (patient with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc.) and ASA Class IV (patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Member requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Members requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.05 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.

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 member has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Partial dentures are covered for members only when there are fewer than eight posterior teeth in occlusion. Four maxillary and four mandibular teeth in functional contact with each other are considered adequate for functional purposes.
- 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 6 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 parenteral/enteral is the member's primary source of nutrients unless dentist submits a plan of care that that indicates dentures or partials are needed to wean the member from the nutritional supplements.
- Anterior tooth replacement is not considered medically necessary by IHCP.
- If there is a pre-existing prosthesis which is not at least 6 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 6 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 6 years old and unserviceable to qualify for replacement.

- Adjustments, repairs and relines are included with the denture fee within the first six 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 five years.

    - Relines will be reimbursed once per denture every 12 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 6 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. At a minimum, this means that a claim for a removable prosthetic appliance should never be submitted prior to the date of service for any extractions necessary for the placement of the prosthesis. This claim submission requirement is also applicable to immediate dentures, since it is anticipated that adjustments to immediate dentures will be required after the date of service of the extractions and initial denture placement.

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

14.06 Criteria for the Excision of Bone Tissue

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

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

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

14.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth 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.

14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Please reference the Exhibits to determine which ADA codes require authorization review. Not all procedures require authorization.

Documentation for authorization of procedure:

Providers must submit a treatment plan, as documented on an ADA claim form, and one or both of the following:

- Additional units beyond six units are subject to review for medical necessity. A time-oriented anesthesia record is the preferred method of documentation. In certain circumstances, as defined within the DentaQuest claims processing system, the number of units that require a narrative of medical necessity may be modified.
- Narrative describing medical necessity for general anesthesia or I.V. sedation for members age 21 and over.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require the documentation as provided above.

Criteria:

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

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying complex medical condition (cerebral palsy, epilepsy, intellectual disability, Down's syndrome) which would render member non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

14.09 Criteria for Periodontal Treatment

Please reference the Exhibits to determine which ADA codes require authorization review. Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred. All radiographs must be of sufficient diagnostic quality to demonstrate the required clinical condition for the CDT code being submitted. Electronic submission of radiographs is preferred. See Section 3.04 - Electronic Attachments for details on submitting documents and radiographs electronically.
- 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:

- Periodontal charting indicating abnormal pocket depths in multiple sites.

- Additionally, it is required that at least one of the following two clinical conditions must be radiographically demonstrated:

  1) adiographic evidence of root surface calculus. Note: If calculus is subgingival, but radiographic evidence shows the calculus is limited to the coronal surface(s) of the tooth or teeth, then the criteria for the presence of calculus on the root surface has not been established and such claims would not qualify for reimbursement of scaling and root planing codes D4341 or D4342.
  2) Radiographic evidence of noticeable loss of bone support. Radiographs must clearly demonstrate a minimum of 2.5 mm bone loss as measured from the cementoenamel junction (CEJ) to the alveolar bone.

- The number of teeth in a quadrant demonstrating the required criteria should be consistent with the definition of the CDT code being submitted.
  - CDT code D4341 (periodontal scaling and root planing - four or more teeth per quadrant) would require that all four teeth be clearly visualized in radiographs submitted and all four teeth would need to meet the criteria stated above.
  - CDT code D4342 (periodontal scaling and root planing – one to three teeth per quadrant) would require that only one tooth be visible in radiographs submitted and only one tooth would need to meet the criteria stated above.

15.00 Interpretation Services

DentaQuest offers telephonic interpretation services for members or providers. If a member or provider would like to arrange for such services, they may contact DentaQuest's Customer Service Department at [855-453-5286.]

16.00 Peer-to-Peer Call

A provider may request a Peer-to-Peer call within 15 days from the date of a denial notice with a DentaQuest dentist who reviews claims, any time he or she wants to understand the clinical basis of why an authorization or claim was denied.

The Peer-to-Peer discussion is limited to the clinical aspects of the claim and not administrative issues such as timely filing or member eligibility. During the call, the DentaQuest dentist can only discuss clinical information during the call and cannot reverse any denials during the call.

To schedule a peer-to-peer call, contact DentaQuest Customer Service, your Provider Engagement Representative, or schedule the call through the portal.

APPENDIX A

General Definitions: The following definitions apply to this Office Reference Manual:

- "DentaQuest" shall refer to DentaQuest, LLC

- "DentaQuest Service Area" shall be defined as the state of Indiana and contiguous geographic areas where out of state providers service PathWays members.

- "Medically Necessary" means those Covered Services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to prevent disease, disability and other adverse health conditions or their progression, or prolong life. In order to be Medically Necessary, the service or supply for medical illness or injury must be determined by plan or its designee in its judgment to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical practice in the community.

- "Managed Care Entity (Humana)" 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.

- "Provider" is a dentist who is contracted with DentaQuest or is an IHCP attested provider.

Additional Resources that can be found on the DentaQuest Provider Portal:

Welcome to the DentaQuest provider forms and attachment resource page. To view this Office Reference Manual electronically and to log into our Provider Web Portal, please visit our website at https://providers.dentaquest.com/onboarding/start/.

Once you have entered the website, click on the "Dentists" icon then select, Indiana. You will then select "Dentist Page" to view relevant HIP and Hoosier Healthwise program information or "Login" to visit our Provider Web Portal page. You can login using your password and User ID for the Provider Web Portal and select the link "Document List" to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Recall Examination Form
- Authorization for Dental Treatment
- Electronic Funds Transfer Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- HIPAA Companion Guide

Additional Resources for Indiana Medicaid:

- Indiana Medicaid Policy Manual:
  https://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-eligibility-policy-manual/

- IHCP Provider Modules:
  [https://www.in.gov/medicaid/providers/810.htm]

- Indiana Code 12-15:
  [http://iga.in.gov/legislative/laws/2018/ic/titles/012#12-15]

- 405 Indiana Administrative Code:
  http://iac.iga.in.gov/iac/iac_title?iact=405

If you do not have internet access, to have a copy of the Office Reference Manual mailed, you may contact DentaQuest Customer Service at [855-453-5286.]

- **American Dental Association Claim Form and submission guidelines**
  - ADA Dental Claim Form | American Dental Association

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	*B/P*	*RDH/DDS*

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

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

COMMENTS: _____

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

Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST, LLC

INSTRUCTIONS

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

MAINTENANCE TYPE:

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

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____ Checking

_____ Personal _____ Business (choose one)

Bank Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

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

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

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

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

_____ _____
Date Print Name

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

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

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

MEDICAL AND DENTAL HISTORY

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

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

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of 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.

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. Providers with benefit questions should contact DentaQuest's Customer Service department directly at:

Humana Healthy Horizons in Indiana PathWays for Aging – [866--274-5888]

Available Monday-Friday
8 a.m – 8 p.m. (EST)

Dental offices are not allowed to charge members for missed appointments. Humana members are to be allowed the same access to dental treatment, as any other patient in the dental practice.

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 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; (e.g., a separate occlusal and buccal restoration on tooth 30 will be reimbursed as one OB two-surface restoration).

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

American Dental Association
A211 East Chicago Avenue
Chicago, IL 60611
[800-947-4746]

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

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

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

Exhibit A Benefits Covered for
PathWays for Aging

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 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 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.
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 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 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.
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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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	60 and older		No	One of (D0120) per 6 Month(s) Per patient. Not allowed within 6 months of D0150 by the same provider.	
D0140	limited oral evaluation-problem focused	60 and older		No	Not reimbursable on the same day as D0120, D0150, D0160, D9310 or D9430. Not used in conjunction with a regular appointment. Not intended for follow up care.	
D0150	comprehensive oral evaluation - new or established patient	60 and older		No	Two of (D0150) per 1 Year(s) Per patient. One of (D0150) per 1 Lifetime Per Provider.	
D0160	detailed and extensive oral eval-problem focused, by report	60 and older		No	One of (D0160) per 1 Lifetime Per Provider.	
D0170	re-evaluation, limited problem focused	60 and older		No		

Exhibit A Benefits Covered for PathWays for Aging

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0210	intraoral - comprehensive series of radiographic images	60 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider.	
D0220	intraoral - periapical first radiographic image	60 and older	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	One of (D0220) per 12 Month(s) Per Provider.	
D0230	intraoral - periapical each additional radiographic image	60 and older	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	One of (D0230) per 1 Day(s) Per patient per tooth. Seven of (D0230) per 12 Month(s) Per patient.	
D0240	intraoral - occlusal radiographic image	60 and older		No	Two of (D0240) per 1 Day(s) Per patient.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	60 and older		No	Two of (D0250, D0251) per 1 Day(s) Per patient.	
D0251	extra-oral posterior dental radiographic image	60 and older		No	Two of (D0250, D0251) per 1 Day(s) Per patient.	
D0270	bitewing - single radiographic image	60 and older		No	Four of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. A total of four horizontal bitewing films in any combination of D0270, D0272, D0273, or D0274 per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0277.	
D0272	bitewings - two radiographic images	60 and older		No	Four of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. A total of four horizontal bitewing films in any combination of D0270, D0272, D0273, or D0274 per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0277.	
D0273	bitewings - three radiographic images	60 and older		No	Four of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. A total of four horizontal bitewing films in any combination of D0270, D0272, D0273, or D0274 per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0277.	

Exhibit A Benefits Covered for PathWays for Aging

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	60 and older		No	Four of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. A total of four horizontal bitewing films in any combination of D0270, D0272, D0273, or D0274 per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0277.	
D0277	vertical bitewings - 7 to 8 films	60 and older		No	One of (D0277) per 12 Month(s) Per Provider. Not to be billed in the same 12 months as D0270, D0272, D0273,or D0274.	
D0310	sialography	60 and older		No		
D0330	panoramic radiographic image	60 and older		No	One of (D0210, D0330) per 36 Month(s) Per Provider.	
D0340	cephalometric radiographic image	60 and older		No	Reimbursable every three years (36 months) if clinically indicated.	
D0411	HbA1 in-office point of service testing	60 and older		No	One of (D0411) per 12 Month(s) Per patient.	
D0486	accession of exfoliative cytological smears, microscopic examination, preparation and transmission of written report	60 and older		No		
D0606	Molecular testing for a public health related pathogen, including coronavirus	60 and older		No	To be rendered by provider type 27 only.	

Exhibit A Benefits Covered for PathWays for Aging

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

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	60 and older		No	One of (D1110) per 6 Month(s) Per patient.	
D1301	immunization counseling	60 and older		No		
D1320	tobacco counseling for control and prevention of oral disease	60 and older		No	Counseling to be provided by dentist.	
D1354	application of caries arresting medicament- per tooth	60 and older	Teeth 1 - 32, A - T	Yes	One of (D1354) per 3 Month(s) Per patient per tooth, per surface. No more than 10 teeth per DOS. Cannot be billed within six months of D1351. Must include tooth number. Review must be completed by a dentist with an Indiana license. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	60 and older	Teeth 1 - 32, A - T	No	Not allowed by dental office that provided Initial placement.	
D1557	Removal of fixed bilateral space maintainer- Maxillary	60 and older	Teeth 1 - 32, A - T	No	Not allowed by dental office that provided Initial placement.	
D1558	Removal of fixed bilateral space maintainer- Mandibular	60 and older	Teeth 1 - 32, A - T	No	Not allowed by dental office that provided Initial placement.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	60 and older		No	To be rendered by provider type 27 only.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	60 and older		No	To be rendered by provider type 27 only.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	60 and older		No	To be rendered by provider type 27 only.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	60 and older		No	To be rendered by provider type 27 only.	

Exhibit A Benefits Covered for PathWays for Aging

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	60 and older		No	To be rendered by provider type 27 only.	
D1999	Unspecified preventive procedure, by report	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	

Exhibit A Benefits Covered for PathWays for Aging

It is DentaQuest's expectation that the Primary Care Dentist (PCD) provide basic and advanced dental services to their patients. However, DentaQuest understands that certain procedures may fall beyond the scope or comfort level of the PCD. To avoid the need for a cumbersome referral process, DentaQuest is leaving the entire process in the hands of the providers. However, DentaQuest's Utilization Management department will continually monitor provider referral patterns to assure appropriate placement of patients and allocation of funds.
Reimbursement includes local anesthesia.
In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost.
A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.
Complete root canal therapy includes all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative and fill radiographs.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	60 and older	Teeth 1 - 32, A - T	No	One of (D2140) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	60 and older	Teeth 1 - 32, A - T	No	One of (D2150) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	60 and older	Teeth 1 - 32, A - T	No	One of (D2160) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	60 and older	Teeth 1 - 32, A - T	No	One of (D2161) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	60 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	60 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2331) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	60 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2332) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	60 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2335) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	60 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	60 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2391) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	60 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2392) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit A Benefits Covered for PathWays for Aging

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	60 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2393) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	60 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	60 and older	Teeth 1 - 32	No	One of (D2910) per 12 Month(s) Per patient. Not billable within 6 months of initial placement	
D2920	re-cement or re-bond crown	60 and older	Teeth 1 - 32, A - T	No	One of (D2920) per 12 Month(s) Per patient per tooth. Not billable within 6 months of initial placement	
D2921	Reattachment of tooth fragment, incisal edge or cusp	60 and older	Teeth 2 - 15, 18 - 31, A - T	No		
D2930	prefabricated stainless steel crown - primary tooth	60 and older	Teeth A - T	No	One of (D2930, D2931, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.	
D2931	prefabricated stainless steel crown-permanent tooth	60 and older	Teeth 1 - 32	No	One of (D2930, D2931, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.	
D2932	prefabricated resin crown	60 and older	Teeth 1 - 32, A - T	No	One of (D2930, D2931, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.	
D2933	prefabricated stainless steel crown with resin window	60 and older	Teeth 2 - 15, 18 - 31, A - T	No	One of (D2930, D2931, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.	

Exhibit A Benefits Covered for PathWays for Aging

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	60 and older	Teeth A - T	No	One of (D2930, D2931, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction.	
D2940	Placement of interim direct restoration.	60 and older	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2941	Interim therapeutic restoration - primary dentition	60 and older	Teeth A - T	No	One of (D2941) per 1 Lifetime Per patient per tooth.	
D2949	Restorative foundation for an indirect restoration	60 and older	Teeth 1 - 32	No		
D2951	pin retention - per tooth, in addition to restoration	60 and older	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth. Limited to permanent molars; used in conjunction with D2160, D2161, D2931, or D2932. Lifetime maximum of two per molar.	
D2976	band stabilization – per tooth	60 and older	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		
D2980	crown repair, by report	60 and older	Teeth 1 - 32	No	Not billable within 6 months of initial placement	
D2990	Resin infiltration of incipient smooth surface lesions	60 and older	Teeth 1 - 32, A - T	No	One of (D2990) per 1 Lifetime Per patient per tooth.	

Exhibit A Benefits Covered for PathWays for Aging

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Reimbursement includes local anesthesia.

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	60 and older	Teeth 1 - 32, A - T	No	Shall not be billed in conjunction with D3310, D3320, or D3330 on the same day.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	60 and older	Teeth 1 - 32, A - T	No	Cannot be done in conjunction with root canal therapy.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	60 and older	Teeth C - H, M - R	No	Cannot be done in conjunction with root canal therapy.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	60 and older	Teeth A, B, I - L, S, T	No	Cannot be done in conjunction with root canal therapy.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	60 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	60 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	60 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	60 and older	Teeth 6 - 11, 22 - 27	No	One of (D3346) per 1 Lifetime Per patient per tooth.	
D3347	retreatment of previous root canal therapy - premolar	60 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3347) per 1 Lifetime Per patient per tooth.	
D3348	retreatment of previous root canal therapy-molar	60 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3348) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	60 and older	Teeth 1 - 32	No	One of (D3351) per 1 Lifetime Per patient per tooth. Includes first phase of complete root canal therapy.	

Exhibit A Benefits Covered for PathWays for Aging

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3352	apexification/recalcification - interim medication replacement	60 and older	Teeth 1 - 32	No	For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.	
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	60 and older	Teeth 1 - 32	No	Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)	
D3410	apicoectomy - anterior	60 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	60 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	60 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	60 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Two of (D3426) per 1 Lifetime Per patient per tooth. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s)
D3427	Periradicular surgery without apicoectomy	60 and older	Teeth 1 - 32	Yes	One of (D3427) per 1 Lifetime Per patient per tooth. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s)
D3430	retrograde filling - per root	60 and older	Teeth 1 - 32	No	One of (D3430) per 1 Lifetime Per patient per tooth.	
D3911	intraorifice barrier	60 and older	Teeth 1 - 32	No		
D3921	decoronation or submergence of an erupted tooth	60 and older	Teeth 1 - 32	No	One of (D3921) per 1 Lifetime Per patient per tooth.	

Exhibit A Benefits Covered for
PathWays for Aging

It is DentaQuest's expectation that the Primary Care Dentist (PCD) provide basic and advanced dental services to their patients. However, DentaQuest understands that certain procedures may fall beyond the scope or comfort level of the PCD. To avoid the need for a cumbersome referral process, DentaQuest is leaving the entire process in the hands of the providers. However, DentaQuest's Utilization Management department will continually monitor provider referral patterns to assure appropriate placement of patients and allocation of funds.
A preformed denture with teeth already mounted forming a denture module is not a covered service.
Complete and/or partial dentures will be approved only when existing prostheses are not serviceable or cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch.
Partial dentures will be approved only when they are required to alleviate a serious health condition including one that affects employability. Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. Missing anterior teeth do not qualify for approval if eight natural or prosthetic posterior teeth are in occlusion.

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

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes.	
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	A minimum of one (1) tooth in the affected quadrant.	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	60 and older	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	Not allowed if D4210 or D4211 has been previously billed in the same quadrant.	
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. Review must be completed by a dentist with an Indiana license.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. Review must be completed by a dentist with an Indiana license.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 24 Month(s) Per patient per quadrant. Review must be completed by a dentist with an Indiana license.	pre-op x-ray(s), perio charting

Exhibit A Benefits Covered for PathWays for Aging

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	60 and older	Teeth 1 - 32	No		
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	60 and older	Teeth 1 - 32	No		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four(4) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120. Review must be completed by a dentist with an Indiana license.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of one (1) to three (3) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120.	pre-op x-ray(s), perio charting
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	60 and older		No	One of (D4346) per 24 Month(s) Per patient. Full-mouth scaling services cannot be performed in six months of CDT codes D1110, D1120, D4341, D4342, D4355, and D4910.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	60 and older		Yes	One of (D4355) per 24 Month(s) Per patient. Full-mouth debridement cannot be performed in six months of CDT codes D1110, D1120, D4341, D4342, D4346, and D4910. Review must be completed by a dentist with an Indiana license.	pre-op x-ray(s), perio charting
D4910	periodontal maintenance procedures	60 and older		No	One of (D4910) per 3 Month(s) Per patient. Not covered within 6 months of D4341 or D4342.	

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 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 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.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	60 and older		Yes	One of (D5110, D5130) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5120	complete denture - mandibular	60 and older		Yes	One of (D5120, D5140) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5130	immediate denture - maxillary	60 and older		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 72 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5140	immediate denture - mandibular	60 and older		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 72 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	60 and older		Yes	One of (D5211, D5213, D5225) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	60 and older		Yes	One of (D5212, D5214, D5226) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	60 and older		Yes	One of (D5211, D5213, D5225) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	60 and older		Yes	One of (D5212, D5214, D5226) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5225	maxillary partial denture-flexible base	60 and older		Yes	One of (D5211, D5213, D5225) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5226	mandibular partial denture-flexible base	60 and older		Yes	One of (D5212, D5214, D5226) per 72 Month(s) Per patient. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	60 and older		No		
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	60 and older		No		
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	60 and older	Per Quadrant (UL, UR)	Yes	One of (D5282) per 72 Month(s) Per patient per quadrant. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph

Exhibit A Benefits Covered for PathWays for Aging

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	60 and older	Per Quadrant (LL, LR)	Yes	One of (D5283) per 72 Month(s) Per patient per quadrant. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D5284) per 72 Month(s) Per patient per quadrant. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D5286) per 72 Month(s) Per patient per quadrant. For replacement of dentures or partials less than 6 years old medical necessity must be established. Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D5511	repair broken complete denture base, mandibular	60 and older	Per Arch (02, LA)	Yes	Not allowed within 6 months of initial placement. Review must be completed by a dentist with an Indiana license.	
D5512	repair broken complete denture base, maxillary	60 and older	Per Arch (01, UA)	Yes	Not allowed within 6 months of initial placement. Review must be completed by a dentist with an Indiana license.	
D5520	replace missing or broken teeth - complete denture - per tooth	60 and older	Teeth 1 - 32, A - T	Yes	Review must be completed by a dentist with an Indiana license.	
D5611	repair resin partial denture base, mandibular	60 and older	Per Arch (02, LA)	Yes	One of (D5611) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	
D5612	repair resin partial denture base, maxillary	60 and older	Per Arch (01, UA)	Yes	One of (D5612) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	
D5621	repair cast partial framework, mandibular	60 and older	Per Arch (02, LA)	Yes	Three of (D5621) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	
D5622	repair cast partial framework, maxillary	60 and older	Per Arch (01, UA)	Yes	Three of (D5622) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	

Exhibit A Benefits Covered for PathWays for Aging

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken retentive/clasping materials per tooth	60 and older	Teeth 1 - 32	Yes	Three of (D5630) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	
D5640	replace missing or broken teeth – partial denture – per tooth	60 and older	Teeth 1 - 32, A - T	Yes	Review must be completed by a dentist with an Indiana license.	
D5650	add tooth to existing partial denture – per tooth	60 and older	Teeth 1 - 32, A - T	Yes	One of (D5650) per 12 Month(s) Per patient. Review must be completed by a dentist with an Indiana license.	
D5660	add clasp to existing partial denture	60 and older	Teeth 1 - 32, A - T	Yes	Review must be completed by a dentist with an Indiana license.	
D5730	reline complete maxillary denture (chairside)	60 and older		No	One of (D5730) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	60 and older		No	One of (D5731) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	60 and older		No	One of (D5740) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5741	reline mandibular partial denture (chairside)	60 and older		No	One of (D5741) per 12 Month(s) Per patient. Not covered within 6 months of placement.	
D5750	reline complete maxillary denture (laboratory)	60 and older		Yes	One of (D5750) per 12 Month(s) Per patient per tooth. Not covered within 6 months of placement. Review must be completed by a dentist with an Indiana license.	
D5751	reline complete mandibular denture (laboratory)	60 and older		Yes	One of (D5751) per 12 Month(s) Per patient per tooth. Not covered within 6 months of placement. Review must be completed by a dentist with an Indiana license.	
D5760	reline maxillary partial denture (laboratory)	60 and older		Yes	One of (D5760) per 12 Month(s) Per patient. Not covered within 6 months of placement. Review must be completed by a dentist with an Indiana license.	

Exhibit A Benefits Covered for PathWays for Aging

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5761	reline mandibular partial denture (laboratory)	60 and older		Yes	One of (D5761) per 12 Month(s) Per patient. Not covered within 6 months of placement. Review must be completed by a dentist with an Indiana license.	
D5765	soft liner for complete or partial removable denture – indirect	60 and older	Per Arch (01, 02, LA, UA)	No	One of (D5765) per 1 Day(s) Per patient.	
D5876	Use of metal substructure in removable complete dentures without a framework	60 and older	Per Arch (01, 02, LA, UA)	Yes	Review must be completed by a dentist with an Indiana license.	narrative of medical necessity

Exhibit A Benefits Covered for
PathWays for Aging

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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 or demonstrated malocclusion causing a shifting of existing dentition.

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	60 and older	Per Arch (01, 02, LA, UA)	No	One of (D5993) per 12 Month(s) Per patient.	
D5999	unspecified maxillofacial prosthesis, by report	60 and older		Yes		

Exhibit A Benefits Covered for PathWays for Aging

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

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6089	accessing and retorquing loose implant screw – per screw	60 and older	Teeth 1 - 32	No		
D6096	remove broken implant retaining screw	60 and older	Teeth 1 - 32	No	One of (D6096) per 60 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement.	

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PathWays for Aging

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Reimbursement includes local anesthesia.
General Anesthesia and IV Sedation will be received on a case by case basis for medical necessity.

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	60 and older		No	Not allowed within 6 months of initial placement.	
D6980	fixed partial denture repair	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed within 6 months of initial placement.	

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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 or demonstrated malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	60 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	60 and older	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		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	60 and older	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	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
D7220	removal of impacted tooth-soft tissue	60 and older	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		
D7230	removal of impacted tooth-partially bony	60 and older	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		
D7240	removal of impacted tooth-completely bony	60 and older	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		

Exhibit A Benefits Covered for PathWays for Aging

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	60 and older	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		
D7250	surgical removal of residual tooth roots (cutting procedure)	60 and older	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		
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	60 and older	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		
D7259	nerve dissection	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D7260	oroantral fistula closure	60 and older		No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	60 and older	Teeth 2 - 15, 18 - 31	No	Includes splinting and/or stabilization.	
D7280	Surgical access of an unerupted tooth	60 and older	Teeth 1 - 32	No	One of (D7280) per 1 Lifetime Per patient per tooth.	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	60 and older	Teeth 1 - 32	No	One of (D7282) per 1 Lifetime Per patient per tooth.	
D7284	excisional biopsy of minor salivary glands	60 and older		No		
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	60 and older		No		Pathology report
D7286	incisional biopsy of oral tissue-soft	60 and older		No		Pathology report
D7288	brush biopsy - transepithelial sample collection	60 and older		No		Pathology report
D7295	Harvest of bone for use in autogenous grafting procedure	60 and older		No		pre-operative x-ray(s) or digital photograph
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s) or digital photograph

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s) or digital photograph
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311, D7320, D7321) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s) or digital photograph
D7410	radical excision - lesion diameter up to 1.25cm	60 and older		No		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	60 and older		No		Pathology report
D7412	excision of benign lesion, complicated	60 and older		No		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	60 and older		No		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	60 and older		No		Pathology report
D7415	excision of malignant lesion, complicated	60 and older		No		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	60 and older		No		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	60 and older		No		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	60 and older		No		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	60 and older		No		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	60 and older		No		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	60 and older		No		Pathology report
D7471	removal of exostosis - per site	60 and older	Per Arch (01, 02, LA, UA)	No		

Exhibit A Benefits Covered for PathWays for Aging

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7472	removal of torus palatinus	60 and older		No		
D7473	removal of torus mandibularis	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D7485	surgical reduction of osseous tuberosity	60 and older		No		
D7510	incision and drainage of abscess - intraoral soft tissue	60 and older	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		
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	60 and older		No		
D7520	incision and drainage of abscess - extraoral soft tissue	60 and older		No		
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	60 and older		No		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	60 and older		No	Includes closure of oro-antral communication when performed concurrently.	
D7610	maxilla - open reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7620	maxilla - closed reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7640	mandible - closed reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7650	malar and/or zygomatic arch-open reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7660	malar and/or zygomatic arch-closed	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7670	alveolus stabilization of teeth, closed reduction splinting	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7671	alveolus - open reduction, may include stabilization of teeth	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph

Exhibit A Benefits Covered for PathWays for Aging

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7710	maxilla - open reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7720	maxilla - closed reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7730	mandible - open reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7740	mandible - closed reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7750	malar and/or zygomatic arch-open reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7760	malar and/or zygomatic arch-closed reduction	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7770	alveolus-stabilization of teeth, open reduction splinting	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7771	alveolus, closed reduction stabilization of teeth	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph
D7810	open reduction of dislocation	60 and older		No	Definitive diagnosis must corroborate necessary treatment for reimbursement.	
D7820	closed reduction dislocation	60 and older		No	Definitive diagnosis must corroborate necessary treatment for reimbursement.	
D7910	suture small wounds up to 5 cm	60 and older		No		
D7911	complicated suture-up to 5 cm	60 and older		No		
D7912	complex suture - greater than 5cm	60 and older		No		
D7961	buccal / labial frenectomy (frenulectomy)	60 and older		Yes	Two of (D7961) per 1 Day(s) Per patient.	
D7962	lingual frenectomy (frenulectomy)	60 and older		Yes	Two of (D7962) per 1 Day(s) Per patient.	
D7972	surgical reduction of fibrous tuberosity	60 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

Exhibit A Benefits Covered for PathWays for Aging

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7979	non-surgical sialolithotomy	60 and older		No		
D7980	surgical sialolithotomy	60 and older		No		
D7982	sialodochoplasty	60 and older		No		
D7983	closure of salivary fistula	60 and older		No	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
D7999	unspecified oral surgery procedure, by report	60 and older		Yes	Review must be completed by a dentist with an Indiana license.	pre-operative x-ray(s) or digital photograph

Exhibit A Benefits Covered for PathWays for Aging

It is DentaQuest's expectation that the Primary Care Dentist (PCD) provide basic and advanced dental services to their patients. However, DentaQuest understands that certain procedures may fall beyond the scope or comfort level of the PCD. To avoid the need for a cumbersome referral process, DentaQuest is leaving the entire process in the hands of the providers. However, DentaQuest's Utilization Management department will continually monitor provider referral patterns to assure appropriate placement of patients and allocation of funds.
Reimbursement includes local anesthesia.
General Anesthesia and IV Sedation will be received on a case by case basis for medical necessity.

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**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9120	fixed partial denture sectioning	60 and older		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	60 and older		Yes	One of (D9230) per 1 Day(s) Per patient. Cannot be billed on same date of service as D9222, D9223, D9239, D9243, D9248. Review must be completed by a dentist with an Indiana license.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	60 and older		Yes	One of (D9239) per 1 Day(s) Per patient. Cannot be billed on same date of service as D9222, D9223, D9230, D9248. Review must be completed by a dentist with an Indiana license.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	60 and older		Yes	Five of (D9243) per 1 Day(s) Per patient. Additional units beyond five are subject to review for medical necessity. A time-oriented anesthesia record is the preferred method of documentation. Cannot be billed on same date of service as D9222, D9223, D9230, D9248. review must be completed by a dentist with an Indiana license.	narrative of medical necessity
D9248	non-intravenous moderate sedation	60 and older		Yes	One of (D9248) per 1 Day(s) Per patient. Cannot be billed on same date of service as D9222, D9223, D9230, D9239, D9243. Review must be completed by a dentist with an Indiana license.	narrative of medical necessity
D9920	behavior management, by report	60 and older		Yes	One of (D9920) per 1 Day(s) Per patient. May be reported in addition to treatment provided. Review must be completed by a dentist with an Indiana license.	narrative of medical necessity
D9942	repair and/or reline of occlusal guard	60 and older		No		

Exhibit A Benefits Covered for PathWays for Aging

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9947	custom sleep apnea appliance fabrication and placement	60 and older	Per Arch (01, 02, LA, UA)	Yes	• Face-to-face evaluation completed by a provider before sleep test to assess the member for obstructive sleep apnea.• The sleep test must meet one of the following:– AHI or RDI is greater than or equal to 15 and less than 30 events per hour and:? Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine– AHI or RDI is equal to or greater than 30 events per hour	
D9948	adjustment of custom sleep apnea appliance	60 and older	Per Arch (01, 02, LA, UA)	No		
D9949	repair of custom sleep apnea appliance	60 and older	Per Arch (01, 02, LA, UA)	No		
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	60 and older		No		
D9995	teledentistry – synchronous; real-time encounter	60 and older		No	must be billed with D0140 or D1320. Claims require POS code 02 or 10.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	60 and older		No	must be billed with D0140 or D1320. Claims require POS code 02 or 10.	