



DentaQuest of Kentucky, Inc. Medicaid and CHIP Office Reference Manual

Humana Healthy Horizons

Please refer to your Participation Agreement for plans in which you contract.

**DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906**

<http://www.DentaQuest.com/Kentucky>

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**DentaQuest* of Kentucky, Inc.
Address and Telephone Numbers**

DentaQuest Corporate Office Address:

11100 W Liberty Drive
Milwaukee, WI 53244

Kentucky Provider Services:

DentaQuest General Provider Services Queue:
(800) 508-6787

Fax numbers:

Claims to be processed:
(262) 834-3589

Email Addresses:

Claims Questions:
denclaims@DentaQuest.com

Eligibility or Benefit Questions:
denelig.benefits@DentaQuest.com

Fraud Hotline:

(800) 237-9139

Review & Referral Requests should be sent to:

DentaQuest – UM Department
P.O. Box 2906
Milwaukee, WI 53201-2906

Credentialing:

P.O. Box 2906
Milwaukee, WI 53201-2906

Fax: (262) 241-7401

Credentialing Hotline:

(800) 233-1468

General TTY Number:

(800) 466-7566

Humana TTY Number:

(800) 855-2880

Claims should be sent to:

DentaQuest - Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:

Direct entry on the web – www.DentaQuest.com

Or

Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
P.O. Box 2906
Milwaukee, WI 53201

**Short Procedure Unit (SPU) for review of
Operating Room (OR) cases:**

P.O. Box 2906- SPU Department
Milwaukee, WI 53201-2906

Fax line: (262) 834-3575

Kentucky Member Services:

DentaQuest General Member Services Queue:
(855) 343-7405

Humana Healthy Horizons Member Services: (800) 444-9137

DentaQuest of Kentucky, Inc.



The Kentucky Patient's Bill of Rights and Responsibilities

State law requires that health care providers or health care facilities recognize patient rights while rendering dental care and that patients respect the health care providers' or health care facilities' rights to expect certain behavior on the part of the patient. Patients may request a copy of the full text of this law from their health care provider or health care facility. A summary of patients' rights and responsibilities are as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing dental services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the dental care provider, information concerning planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for dental care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to dental treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency dental condition that will deteriorate from failure to receive treatment.
- A patient has the right to know if dental treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Kentucky law, through the grievance process of the dental care provider or dental care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to his or her dental care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the dental care provider.
- A patient is responsible for reporting to his or her dental care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by his or her dental care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the dental care provider or dental care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the dental care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her dental care are fulfilled as promptly as possible.
- A patient is responsible for following dental facility rules and regulations affecting patient conduct.

DentaQuest of Kentucky, Inc. (“DentaQuest”)



Statement of Provider Rights and Responsibilities

Providers shall have the right to:

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

* * *

DentaQuest shall disseminate bulletins as needed to incorporate any needed changes to this ORM.

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

**Office Reference Manual
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1.00 Introduction

The information contained in this Provider Office Reference Manual is intended as a resource for you and your staff. It lists DentaQuest's standard administrative guidelines for claims processing, as well as information regarding DentaQuest's standard policies. In all cases, specific group contract provisions, limitations and exclusions take precedence.

The introductory pages provide general information about DentaQuest's policies. The remaining pages are organized according to the most current edition of the Current Dental Terminology (CDT), published by the American Dental Association (ADA). For complete code descriptions, we strongly encourage you to purchase the most recent edition of the official CDT manual from the ADA by calling 1-800-947-4746 or visiting www.ada.org. The presence of a code in the CDT does not automatically mean that it is a covered benefit.

NOTE: DentaQuest reserves the right to add, delete or change the policies and procedures described in this reference guide at any time.

2.00 General Definitions

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

Adverse Determination: a utilization review decision by the Plan, or a health care provider acting on behalf of the Plan, that:

- a) Decides a proposed or delivered health care service, which would otherwise be covered under this Agreement is not, or was not medically necessary, appropriate or efficient; and
- b) May result in non-coverage of the health care service.

Adverse determination does not include a decision concerning a subscriber's status as a member.

Agreement: refers to the Account Dental Service Agreement, with the Subscriber Certificate(s), Schedule(s) of Benefits, Group Application, Enrollment Form, and any applicable rider(s), Endorsements, and Supplemental Agreements, that represent the complete and integrated Agreement between the parties.

Appeal: a protest filed by a Covered Individual or a health care provider with the Plan under its internal appeal process regarding a coverage decision concerning a Covered Individual.

Appeal Decision: a final determination by the Plan in response to an appeal filed with the Plan under its appeal process regarding a coverage decision concerning a Covered Individual.

Balance Billing: when a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. **An in-network provider may not balance bill for covered services.**

Complaint: an oral or written expression of dissatisfaction with the Utilization Review Agent (URA), concerning the URA's process in conducting a utilization review.

Contracting Dentist: a licensed dentist who has entered into an agreement with the Plan to furnish services to Covered Individuals.

Covered Service: a list of dental procedures for which DentaQuest will reimburse providers. Covered Services are plan-specific.

Date of Service: the actual date that the service was completed. With multi-stage procedures, the date of service is the final completion date (the insertion date of a crown, for example).

DentaQuest Service Area: the Commonwealth of Kentucky.

Effective Date: the date, as shown on the Plan's records, on which the subscriber's coverage begins under this Agreement or an amendment to it.

Emergency Medical Condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B). Emergency dental care includes treatment to relieve acute pain or control dental condition that requires immediate care to prevent permanent harm.

Fee Schedule: the payment amount for the services that DentaQuest has agreed to provide Participating and Non-participating Dentists under their contract.

Filing date: the earlier of a) five (5) days after the date of mailing; or b) the date of receipt.

Grievance: a protest filed by a Covered Individual, a Covered Individual's Representative, or a health care provider acting on behalf of a Covered Individual, with the Plan through the Plan's internal grievance process regarding an adverse determination concerning the Covered Individual.

Grievance Decision: a final determination by the Plan in response to a grievance filed with the Plan under its internal grievance process regarding an adverse determination concerning a Covered Individual.

Medically Necessary: means those Covered Services provided by a dentist, 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 Plan or its designee in its judgment will determine if the service or supply for medical illness or injury is a Covered Service and which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of the dental and medical practice in the community.

Member: means any individual who is eligible to receive Covered Services pursuant to a Contract.

Non-Participating Dentist: a licensed dentist who has not entered into an agreement with the Plan to furnish services to its Covered Individuals.

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

Plan Certificate: means the document that outlines the benefits available to Members.

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

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

Schedule of Benefits: the part of this Agreement which outlines the specific coverage in effect as well as the amount, if any, that Covered Individuals may be responsible for paying towards their dental care.

The Plan: refers to DentaQuest of Kentucky, Inc.

Utilization Review: a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

3.00 Patient Eligibility Verification Procedures

3.01 Plan Eligibility

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

3.02 Member Identification Card

Members will receive a Plan ID Card. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

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

Sample of the Member ID Card:

<Insert ID Cards>

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

3.03 DentaQuest's Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at <http://www.DentaQuest.com/kentucky>. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Provider Services Department; however, by utilizing either system, you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Services Representative.

Access to eligibility information via the DentaQuest Website:

DentaQuest's website currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply go to the website at <http://www.DentaQuest.com/kentucky>. Once you have entered the website, click the link called "Login." You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instructions on how to complete Provider Self Registration contact DentaQuest's Provider Services Department at (800) 508-6787. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check up to 30 patients at a time and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line:

To access the IVR, simply call DentaQuest's Provider Services Department at (800) 508-6787 and press 2 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Provider Services Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid, CHIP or Medicare Member by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Provider Services Representative.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

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

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

If you are having difficulty accessing either the IVR or website, please contact the Provider Services Department at (800) 508-6787. They will be able to assist you in utilizing either system.

3.04 Appointment Availability/ Appointment Waiting Time

Providers must be available within the appointment availability standards prescribed by DentaQuest.

Appointment Access & Availability Standards – Section 3 (k) of our Dental Provider Service Agreement stipulates that providers are required to meet appointment availability standards. Surveys are conducted randomly throughout the year to ensure providers are meeting these standards. If you are not able to provide appointments within these standards, please notify your Provider Engagement Representative:

- **Urgent appointments within 48 hours of request**
Urgent appointments include, but are not limited to, a chipped tooth, sensitivity, or mild pain.
- **Routine care appointments within 30 days of request**
Routine care includes, but is not limited to, a cleaning or a checkup.

3.05 Changes in Your Practice

In order for DentaQuest to maintain its records, and to ensure the appropriate members are referred to or can reach you, it is required that you notify us if there are any changes to your practice. Please let us know immediately if any changes occur including:

- Moves or additional locations
- Hours of operation
- Phone/fax number changes
- Changes to member populations seen
- Email addresses

3.06 Material Change Notification

DentaQuest communicates with all participating providers any material changes to the existing provider contract following regulatory guidelines. If a material change is made, the provider will be provided with at least 90 days' notice the following information:

- Effective date of the change
- Description of the change to the existing contract
- Notification of providers option to accept or reject the change
- Contact information for a representative at Humana Healthy Horizons to discuss the change

Additionally, the provider has the opportunity to request a meeting to discuss concerns about the change with DentaQuest. If DentaQuest has cause to make three or more material changes to a contract in a rolling 12 month period, the participating provider may request an updated copy of the contract for informational purposes. This updated contract with changes consolidated will have no effect on the terms and conditions of the contract.

In the event the provider would like to oppose the material change to the contract, the provider should submit any objections in writing within 30 days of receiving the notification of the change. A DentaQuest representative will then work to come to an agreement on the change over the following 30 days. If an agreement cannot be reached between DentaQuest and the provider, Providers will have 30 days to terminate the contract and provide notice to members to prevent any gaps in care caused by this dissolution.

If you have any questions, please contact Customer Service at (800) 508-6787. You may also contact your local Provider Engagement Representative.

4.00 Emergency Care Requirements (All Plans)

In providing for emergency services and care as a covered service, DentaQuest shall not:

1. Require a referral or prior authorization for emergency service and care.
2. Indicate that emergencies are covered only if care is secured within a certain period of time.
3. Use terms such “life threatening” or “bona fide” to qualify the kind of emergency that is covered.
4. Deny payment based on the member’s failure to notify DentaQuest in advance or within a certain period of time after the care is given.

Emergency Dental Condition – a dental or oral condition that requires immediate service for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums.

Emergency Dental Services – those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structure (periodontal membrane, Gingival, alveolar bone), jaws, and tissues of the oral cavity.

Urgent Care – those problems, which, though not life threatening, could result in serious injury or disability unless attention is received or do substantially restrict a member’s activity.

Hospital Emergency Services:

When a member is present at a hospital seeking emergency services and care, the determination as to whether an emergency dental condition exists shall be made, for the purpose of treatment, by a dentist or a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the hospital dentist or physician. The dentist or physician, or appropriate personnel shall indicate in the patient’s chart the results of the screening, evaluations, and examination.

If the member’s primary care dentist responds to the notification, the hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member.

Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient, in accordance with federal law to determine if the patient is a member of DentaQuest, if emergency services and care are not delayed.

DentaQuest shall compensate the dental provider for any dental services that are incidental to the screening, evaluation, and examination that are reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient’s condition is an emergency dental condition.

DentaQuest shall compensate the dental provider for emergency dental services and care as long as member was eligible for services at time of treatment and services provided were medically necessary. If a determination is made that an emergency dental condition does not exist, DentaQuest is not responsible for payment for services rendered subsequent to that determination.

DentaQuest shall not deny payment for emergency services and care.

5.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office. To get the most current list of participating hospitals with Humana Healthy Horizons, please call Provider Services at 1-855-661-2028.

Please refer to section 16.05, Criteria for Review of Operating Room (OR) cases, of this ORM for information on Operating Room (OR) criteria.

5.01 Hospital Case Management

All nonemergency hospital cases require review and approval by DentaQuest. Only cases with the following conditions will be considered:

- Medically Compromised Patients
- Severe Behavior Management Cases
- Complex Restorative Cases

In the event that any procedures are not consistent with our guidelines, DentaQuest reserves the right to deny the prior authorization.

5.02 Payment for Non-Covered Services

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

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

A recommended Member Consent Form can be found on the DentaQuest Provider Web Portal and attached to the end of this manual.

6.00 Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data

For each plan that DentaQuest administers, the plans may require review of certain procedures to ensure that procedures meet the requirements of federal and state laws and regulations and medical necessity criteria. DentaQuest performs the review using one of two processes – "prior authorization" or "prepayment review".

- "Prior Authorization" requires that the provider obtain permission to perform the procedure prior to performing the service. "Prior Authorization" requires specific documentation to establish medical necessity or justification for the procedure.
- "Prepayment Review" is the review of claims prior to determination and payment. "Prepayment Review" requires documentation to establish medical necessity or justification for the procedure. For procedures that require "Prepayment Review", providers may opt to submit a "Prior Authorization" request prior to performing the procedure. If DentaQuest approves the "Prior Authorization" request, it will satisfy the "Prepayment Review" process.

The Exhibits for each plan indicate which procedures require Review, which type of Review, and the documentation that the provider will need to submit to support his or her request.

Participating Providers will not be paid if this “documentation” is not provided to DentaQuest.

Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered). DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see section 14). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered. It is DentaQuest's policy to refrain from offering any encouragement or financial incentives to its Dental Directors or Benefit Examiners to render adverse determinations. All review staff employed or contracted by DentaQuest signs an attestation to this policy and the original signature is maintained in the staff's personnel file in the Human Resource Department.

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.

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

- Electronic claims via DentaQuest's website (www.DentaQuest.com/Kentucky).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File
- Paper claims.

DentaQuest utilizes claims submissions and information to collect encounter data.

6.01 Electronic Attachments

DentaQuest accepts dental radiographs electronically via FastAttach™ for review requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontics charts, intraoral pictures, narratives and EOBs. FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach, go to www.fast.nea.com or call NEA at: 1(800) 782-5150.

6.02 Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review

- Electronic submission using the web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the “Learn More” button. To register, click the “Provider Registration” button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent

separately and any radiographs received without a SASE will not be returned to the sender.

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

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

6.03 Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Internet Website

Participating Providers may submit Prior Authorizations or Claims including claims requiring Prepayment Review directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Prior Authorizations or Claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit prior authorizations or claims via the website, simply log on to www.DentaQuest.com/Kentucky. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Services Department at (800) 508-6787. Once logged in, select "Claims/Prior Authorizations" and then either "Dental Pre-Auth Entry" or "Dental Claim Entry" depending if you are submitting a Prior authorization or a claim.

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

If you have questions on submitting prior authorizations or claims or accessing the website, please contact our Systems Operations Department at (888) 560-8135 or via e-mail at: EDITeam@DentaQuest.com

Authorization Review

KRS 304.17A-600 to 304.17A-633 requires written procedures for coverage and utilization review determinations to be accessible on insurers' Web sites -- Preauthorization review requirements for insurers. (Effective January 1, 2020)

All applicable utilization management policy & procedures will be maintained, updated and made accessible on the DentaQuest dental home page. <https://www.dentaquest.com/state-plans/regions/kentucky/dentist-page/>

Time Frames

Unless specified differently by the Plan or regulation, determinations are completed within the following time frames from the receipt of the request:

- a. Standard: two (2) business days
- b. Emergent/Urgent: 24 hours
 - DentaQuest does not require any authorization for emergency services.

Authorization Listing

- a. When adding or removing a preauthorization, a request is sent to the client/ State for review and approval.
- b. After approvals are granted, the latest version of the authorization listing is updated in the ORM and made visible online that will reflect an effective or term date of the authorization.
- c. In accordance to KRS 304.17A-603(4) (a) & (b). DentaQuest will not deny a claim for failure to obtain preauthorization requirements if the preauthorization was posted with an effective date at the time of the date of service referenced on the claim.

6.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor 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.

6.05 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@DentaQuest.com to inquire about this option for electronic claim submission.

6.06 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest Dental.

- 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 Dental in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest Dental you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest Dental through a clearinghouse or through a direct integration you need to review your integration to assure that it is in

compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

6.07 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms (2012 or newer ADA claim form) or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

DentaQuest – Claims
P.O.Box 2906
Milwaukee, WI 53201-2906

6.08 Coordination of Benefits (COB)

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

6.09 Filing Limits

Providers have up to 365 days after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit 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.

6.10 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Provider Services 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.

6.11 Direct Deposit

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form that can be found on the website (www.DentaQuest.com/Kentucky).
- 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.

By Fax – 1-262-241-4077

By Mail – DentaQuest, LLC
P.O. Box 2906
Milwaukee, WI 53201-2906
ATTN: Standard Updates

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

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

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

1. Login to the PWP at www.DentaQuest.com/Kentucky
2. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

6.12 Provider Recognition in State Medicaid Program

DentaQuest is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the PDHP and that the provider's submission of encounter data is accepted by DentaQuest and Kentucky MMIS and/or the state's encounter data warehouse.

7.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures also compliant with the Privacy Standards. DentaQuest is compliant with Administrative Simplification and Security Standards. One aspect of our compliance plan is to work cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, provider contracts reflect the appropriate HIPAA compliance language.

The contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards recognized by the American Dental Association's Current Dental Terminology (CDT) codes. Effective the date of this manual, DentaQuest will require providers to submit all claims with the current CDT codes. 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 Provider Services Department at (800) 508-6787 or via e-mail at denelig.benefits@DentaQuest.com.

7.01 HIPAA Companion Guide

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

8.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series)

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

A. Definitions:

Complaint: A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include but are not limited to the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights.

Appeal: A formal request from an enrollee to seek a review of an action taken by the Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an action.

Expedited Appeal: An expedited request for review of an action. An Expedited appeal should be processed when it is determined that allowing the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such determination is based on:

1. A request from the Member
2. A provider's support of a member's request
3. A provider's request on behalf of the member or
4. The plans' determination.

B. Complaints/Grievance Staff:

DentaQuest assists Humana Healthy Horizons with the grievance process. Members are directed to send their grievances to Humana. Providers acting on behalf of the member would also submit their grievance to Humana Healthy Horizons. Humana Healthy Horizons will contact DentaQuest for assistance to resolve the grievance. The DentaQuest Complaints/Grievance Coordinator receives Provider grievances when the provider is acting on their own behalf.

When DentaQuest receives the request for assistance from Humana Healthy Horizons or receives the request from a Provider, 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. Plan, and Provider as applicable).

For grievances received from the member or the Provider acting on the member's behalf, DentaQuest communicates the recommendation to Humana Healthy Horizons. Humana Healthy Horizons will communicate the resolution to the member. DentaQuest will communicate the resolution to the provider directly when the provider is acting on their own behalf. The grievance will be closed and maintained on file for tracking and trending purposes.

DentaQuest assists Humana Healthy Horizons with the appeal process. Members are directed to send their appeals to Humana Healthy Horizons. Providers acting on behalf of the member would also submit the appeal to Humana. Humana will contact DentaQuest for

assistance to

resolve the appeal received. Providers acting on their own behalf for pre or post-service or claim payment appeals should submit the request to DentaQuest.

The DentaQuest Complaints/Grievance Coordinator requests appropriate documentation, forwards the documentation to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified of the resolution (i.e. Plan, and Provider as applicable).

For appeals received from the member or the Provider acting on the member's behalf, DentaQuest communicates the recommendation to Humana. Humana will communicate the resolution to the member. DentaQuest will communicate the resolution to the provider directly when the provider is acting on their own behalf for post-service or claim payment appeals. The appeal will be closed and maintained on file for tracking and trending purposes.

Contact information for Humana is located in the table in Section E below.

C. Provider Appeals:

For Pre-Service and Post-Service ~~or~~ claim payment appeal requests, the provider is considered to be acting on their own behalf. The appeal should be submitted to DentaQuest within (60) days of the denial. This can be done by submitting a request for appeal through the provider portal or in writing with a narrative and supporting documentation to the DentaQuest Provider Appeals Coordinator via mail or fax. DentaQuest will resolve the appeal within thirty (30) calendar days of receipt, unless a fourteen (14)-day extension is requested and granted.

All appeals should be sent to the following address:

DentaQuest
Provider Appeals
P.O. Box 2906,
Milwaukee, WI 53201-2906
Fax (262) 834-3452

D. External Review and Administrative Hearing for the Provider:

Under Kentucky statute and regulation 907 KAR 17:035, you have the right to an external, third-party review. Providers may submit a request for an external independent third party review within 60 calendar days of receiving an MCO's final decision from the MCO's internal appeal process. Provider requests pursuant to 907 KAR 17:035 will not be considered for dates of service prior to 12-1-2016.

The sixty (60) day count shall begin on the:

1. Date that the notice was received electronically, if received electronically;
2. Date that the notice was received via fax, per the date and time documented on the fax transmission, if the notice was faxed; or
3. Post mark date on the envelope containing the notice, if the notice was sent via postal mail. An additional three (3) days shall be added when the service is by mail.

This request must be submitted to the MCO via one of the contact options designated below. DMS will also post the MCO contact information on their website at <http://www.chfs.ky.gov/dms/>. Requests are not accepted verbally. Additional information will not be considered by the third-party reviewer.

- GAMedicaidRightfax@humana.com
- Fax: 800-949-2961
- Mail: Humana Health Plan, Inc., P.O. Box 14546 Lexington, KY 40512-4546

Member's Plan	Telephone	Mail	Fax
Humana Healthy Horizons Plan	800-444-9137	Humana Healthy Horizons, Attn: Grievances and Appeals, P.O. Box 14546, Lexington, KY 40512-4546	800-949-2961

An administrative law judge at the Division of Administration (DOA) will conduct the state fair hearing. When the hearing is complete, the Director of DOA will report the results of the hearing decision to the member, to Humana and to CHFS.

Implementation of such a hearing decision shall not be the basis for termination of enrollment by Humana.

After exhausting both the appeal process of Humana and the hearing process, an enrollee has a right to independent review in accordance with the State Fair Hearing process.

F. Continuation of Benefits during Appeals or State Fair Hearings

Humana Healthy Horizons is required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The request for continuation of benefits is submitted to Humana on or before the latter of the two: within 10 calendar days of mailing the notice of action or the intended effective date of proposed action by Humana
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
 - Services were ordered by an authorized provider
 - The original period covered by the original authorization has not expired
 - The member requests an extension of benefits

If the decision is against the member, Humana may recover the cost of the services the member received while the appeal was pending. This process also applies to all EPSDT appeals decisions.

G. Policy and Procedures:

Copies of DentaQuest's policies and procedures can be requested by contacting Provider Services at (800) 508-6787.

9.00 Utilization Management Program (Policies 500 Series)

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

9.01 Community Practice Patterns

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

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such

variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

9.02 Evaluation

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

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

9.03 Results

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

9.04 Fraud and Abuse (Policies 700 Series)

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

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

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

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.

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

Providers are to cooperate fully in any investigation by the Agency, Medicaid Program Integrity (MPI), or Medicaid Fraud Control Unit (MFCU), or any subsequent legal action that may result from such an investigation.

10.00 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 (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Services Department at (800) 508-6787 or via e-mail at: denelig.benefits@DentaQuest.com

11.00 Credentialing (Policies 300 Series)

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines and plan requirements.

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

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

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

Appeal of Credentialing Committee Recommendations (Policy 300.017)

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

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

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)

Network Providers are recredentialed at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Provider Services Department at (800) 508-6787 or via e-mail at denelig.benefits@DentaQuest.com.

11.01 Termination

DentaQuest, at any time, may terminate a provider for cause or at will for no cause.

If a provider wishes to drop out of the plan, he or she must give DentaQuest thirty (30) days written notice prior to the discontinuance of member services. Additionally, the provider must complete any procedures that are in progress or assist DentaQuest in transferring member to another DentaQuest provider.

12.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:
 - a. Registration data including a complete health history.
 - b. Medical alert predominantly displayed inside 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 patient, (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

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

1. Adequate documentation of registration information which requires entry of these items:
 - a. Patient's first and last name.
 - b. Date of birth.
 - c. Sex.
 - d. Address.
 - e. Telephone number.
 - f. Name and telephone number of the person to contact in case of emergency.
 - g. Information regarding the primary language of the enrollee.
 - h. Information related to the member's needs for translation services.
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.

- n. Summary of significant surgical procedures.
 - o. Treating provider's signature and/or initials must be documented on each date of service.
 - p. Treating provider's signature and/or initials must contain the profession designation (e.g. DDS, DMD, RDH, CDA).
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. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
- a. Periodontal pocket depth.
 - b. Furcation involvement.
 - c. Mobility.
 - d. Recession.
 - e. Adequacy of attached gingiva.
 - f. Missing teeth.
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
- a. Gingival status.
 - b. Amount of plaque.
 - c. Amount of calculus.
 - d. Education provided to the patient.
 - e. Patient receptiveness/compliance.
 - f. Recall interval.
 - g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
 - a. Provider to whom consultation is directed.
 - b. Information/services requested.
 - c. Consultant's response.
13. Adequate documentation of treatment rendered which requires entry of these items:
 - a. Date of service/procedure.
 - b. Description of service, procedure and observation. Documentation in treatment 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 basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
 - c. Type and dosage of anesthetics and medications given or prescribed.
 - d. Localization of procedure/observation. (tooth number, quadrant etc.)
 - e. Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:
 - a. Patient examination.
 - b. Treatment plan.
 - c. Treatment status.

C. Compliance

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

13.00 Patient Recall System Requirements

A. Recall System Requirement

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

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

- “We missed you when you did not come for your dental appointment on month/date. Regular 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.”

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

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government-supported screening program, contact staffs from these programs to ensure that scheduled appointments are kept.

B. Office Compliance Verification Procedures

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- Emergency care must be available 24 hours a day, 7 days a week.
- Urgent care must be available within 48 hours of request.
- Routine care must be available within 30 days of request.

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

14.00 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. Child – Primary Dentition**
The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.
- 2. Child – Transitional Dentition**
The Panel recommends an individualized Periapical/Occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.
- 3. Adolescent – Permanent Dentition Prior to the eruption of the third molars**

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

4. **Adult – Dentulous**

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

5. **Adult – Edentulous**

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

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

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

a. **Child – Primary and Transitional Dentition**

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

b. **Adolescent**

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

c. **Adult – Dentulous**

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

d. **Adult – Edentulous**

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

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

a. **Child – Primary Dentition**

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

b. **Adolescent**

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. **Adult – Dentulous**

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

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent and Dentulous Adult

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

4. Growth and Development Assessment

a. **Child – Primary Dentition**

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. **Child – Transitional Dentition**

The Panel recommends an individualized periapical/occlusal series OR a panoramic radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. **Adolescent**

The Panel recommends that for the adolescent (ages 16-19) recall patient, a single set of periapicals of the wisdom teeth OR a panoramic radiograph.

d. **Adult**

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

14.01 Criteria for Radiographs

American Dental Association (ADA) and American Association of Pediatric Dentists (AAPD) guidelines promote, that the number and type of radiographs should be based on the risk level of the patient and whether or not the provider can visualize the entire tooth. The following link describes current ADA and AAPD guidelines for radiographs.

http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_chart.pdf

Panoramic Radiograph vs. Complete Series (FMX)

It is a fairly common occurrence for providers to perform a panoramic film instead of a full mouth series. Panoramic films alone are not considered sufficient for the diagnosis of decay, and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. In cases where a provider is combining a panoramic film and bitewings, the benefit will equal that of a full mouth series. This down-paying of services aligns with guidelines and the concept of medical necessity (reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide) and, according to the ADA, is a result of requests from the dental community. See section of Reimbursement of Services Rendered below. This section details guidance on reimbursement of services.

15.00 RECOMMENDED HEALTH GUIDELINES – PERIODIC SCHEDULES (AGES 0-18 YEARS)

NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)
Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

PERIODICITY RECOMMENDATIONS					
Age (1)	Infancy 6 – 12 Months	Late Infancy 12 – 24 Months	Preschool 2 – 6 Years	School Aged 6 – 12 Years	Adolescence 12 – 18 Years
Oral Hygiene Counseling (2)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/ parents/ guardians/ caregivers	Patient/ parents/ caregivers	Patient
Injury, Prevention Counseling (3)	X	X	X	X	X
Dietary Counseling (4)	X	X	X	X	X
Counseling for non- nutritive habits (5)	X	X	X	X	X
Fluoride Supplementation (6,7)	X	X	X	X	X
Assess oral growth and development (8)	X	X	X	X	X
Clinical oral exam	X	X	X	X	X
Prophylaxis and topical fluoride treatment (9)		X	X	X	X
Radiographic assessment (10)			X	X	X
Pit and Fissure Sealants			If indicated on primary molars	First permanent molars as soon as possible after eruption	Second permanent molars and appropriate premolars as soon as possible after eruption
Treatment of dental disease	X	X	X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Substance abuse counseling				X	X
Assessment and/or removal of third molars					X
Referral for regular periodic dental care					X
Anticipatory guidance (11)	X	X	X	X	X
<ol style="list-style-type: none"> 1. First examination at the eruption of the first tooth and no later than 12 months. 2. Initially, responsibility of parent; as child develops jointly with parents, then when indicated, only by child. 3. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing. 4. At every appointment discuss role of refined carbohydrates; frequency of snacking. 5. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor. 6. As per American Academy of Pediatrics/American Dental Association guidelines and the water source. 7. Up to at least 16 years. 8. By clinical examination. 9. Especially for children at high risk for caries and periodontal disease. 10. As per AAPD Guideline on Prescribing Dental Radiographs. 11. Appropriate discussion and counseling should be an integral part of each visit for care. 					

16.00 Clinical Criteria

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

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

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

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

16.01 Criteria for Dental Extractions

Not all procedures require review.

Documentation needed for review procedure:

- Appropriate radiographs showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (except for orthodontics) is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars that are asymptomatic, do not exhibit any evidence of pathology, or were extracted for prophylactic reasons only.

1. GP, pedodontist or ortho determines patient may need 3rd molars extracted - no referral is necessary
 - a. Can refer patient directly to DentaQuest oral surgeon.
 - b. Provider or member can call DentaQuest – 1 (800) 508-6787. DentaQuest will assist member in finding an oral surgeon.

2. Oral Surgeon - Submission of treatment for approval
 - a. Non-emergency
 - i. Pre-payment review – performs treatment and submits documentation with claim – no guarantee provider will get paid for service – procedure must meet medical necessity guidelines for DentaQuest to pay.
 - ii. Prior authorization – submit documentation prior to performing treatment. If DentaQuest approves, provider is guaranteed payment as long as patient is eligible on date of service.
 - b. Emergency (treatment necessary within 24 hours) – if want prior approval - fax request to (305) 423-8765. Requests must still include documentation when required.
3. Documentation of medical necessity for oral surgery - evidence of diagnosed pathology or demonstrable need (including ortho), rather than anticipated future pathology.
 - a. Pathology
 - i. Provider must submit narrative and x-rays or photos describing pathology
 - ii. Each tooth must show pathology
 - iii. Symptomology or impactions without pathology may not be enough
 - b. Demonstrable need
 - i. Narrative describing need
 - ii. Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)
 - c. Extractions in conjunction with approved orthodontic treatment
 - i. Provider must submit request for extractions from orthodontist
 - ii. Needs to be an approved orthodontic case
 - iii. To expedite process, provider may also want to submit orthodontic approval
4. General Approval vs. Denial Guidelines
 - a. Probable Approval
 - i. Pathology =
 1. Non-restorable Decay
 2. Tooth erupting on an angle and impinging on 2nd molars
 3. Recurrent Pericoronitis

4. Dentigerous Cyst or other growth
 5. Internal or External Root Resorption
 6. 3rd molar has over-erupted due to lack of opposing tooth contact
 - ii. Demonstrable need =
 1. **In conjunction with approved orthodontics** where orthodontist requests the 3rd molars be removed to guarantee the success of the orthodontic case (provide referral from ortho and prior auth approval of ortho if possible)
 2. **Pain with no pathology** – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need
 - b. Probable Denial
 - i. Impaction or Symptomology =
 1. Impaction with no other pathology
 2. Pain or discomfort with unknown pathology
 - ii. Other 3rd molars have pathology (if one, two, or three teeth show pathology, DentaQuest will not automatically approve the extraction of the remaining non-pathologic teeth)
5. Denials
- a. If administrative denial (e.g. lack of documentation) - Resubmit according to deficiencies noted in EOB
 - b. If clinical denial:
 - i. Resubmit with documentation showing additional clinical evidence for extraction
 - ii. Advise members that the service is not covered
 1. Member can appeal following appeal process in member handbook
 2. Provider and member may work out an out-of-pocket arrangement

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

Alveoloplasty (code D7310) is a covered service only when the procedure is done in conjunction with four or more extractions in the same quadrant.

16.02 Criteria for Cast Crowns

Documentation needed for review of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered without necessary review will still require that sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50 percent of the incisal edge.

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

- Request should include a dated post-endodontic radiograph.
Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex. The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Approval for Crowns will not meet criteria if:

- A more cost effective means of restoration is possible that provides quality care and meets the standard of care.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

16.03 Criteria for Endodontics

Not all procedures require review.

Documentation needed for review of procedure:

- Sufficient and appropriate radiographs showing clearly the adjacent teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

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

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- Root canal treatment limited to permanent teeth or retained primary teeth with no succedaneous permanent teeth.

Approval 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 percent 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.
- Retreatment of previous root canal therapy is a separate procedure (codes D3346, D3347 and D3348) and is generally not a covered service (check the member's plan for covered services).

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.

16.04 Criteria for Stainless Steel Crowns

For most plans, review is not required. Please reference the plan exhibits to determine if review is required for your plan. Where review is required for primary or permanent teeth, the following criteria apply:

Documentation needed for review of procedure:

- Appropriate radiographs or digital photographic images showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

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.

An approval 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/obtured. 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 percent supported in bone.
- Stainless steel crowns on permanent teeth are expected to last five years.

Approval of treatment using stainless steel crowns will not meet criteria if:

- A more cost effective means of restoration is possible that provides quality care and meets the standard of care.
- 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.

16.05 Criteria for Review of Operating Room (OR) Cases

All Operating Room (OR) Cases MUST be reviewed.

Provider must submit the following documents for review via fax to DentaQuest's Short Procedure Unit (SPU) at (262) 834-3575 or via mail to DentaQuest - (or DentaQuest SPU Dept.) P.O. Box 2906 Milwaukee, WI 53201-2906 for review of OR cases:

- Copy of the patient's dental record, including health history, charting of the teeth and existing oral conditions.
- Diagnostic radiographs or caries-detecting intra-oral photographs†.
- Copy of treatment plan. A completed ADA claim form submitted for review may serve as a treatment plan.
- Narrative describing medical necessity for OR.

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

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

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

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

Criteria

In most cases, OR will be approved (for procedures covered by the health plan) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).*
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.*
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.*
- Patients 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.*

* The medical condition should be verified by a PCP narrative, which is submitted with the review request.

16.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for review of procedure:

- Treatment plan.
- Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered without necessary will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

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

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

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

Approval for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months of denture placement.
- A new prosthesis will not be reimbursed within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
- Relines will be reimbursed once per denture every 36 months.
- Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for approval of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

16.07 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-4) is related to the removal of the lateral exostosis. This code is subject to review and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Review requirements:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for 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.

16.08 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.

16.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for review of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for general anesthesia or IV sedation.
- Treatment rendered under emergency conditions, when review is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV 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 (i.e. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be performed.

16.10 Criteria for Periodontal Treatment

Documentation needed for review of procedure:

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

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

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

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

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

Gross Debridement (D4355) is the gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. Providers may only perform a gross debridement if the deposits on the teeth prevent them from performing a complete oral evaluation. Consequently, a provider should not perform an oral evaluation on the same day he/she performs a gross debridement. In such cases the provider should document the condition with photographs to show medical necessity.

Criteria

- A minimum of four (4) teeth affected in the quadrant for code D4341.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:
 1. Radiographic evidence of root surface calculus.
 2. Radiographic evidence of noticeable loss of bone support.
 3. Intra-oral pictures when submitting for codes D4210 and D4211.
 4. Narrative.

16.11 Clinical Criteria for Orthodontics

- Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.
- Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicusps are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.
- Orthodontic care is limited to correcting a disabling malocclusion for transitional, full permanent dentition or for treatment of a cleft palate or severe facial anomaly.

All orthodontic services require prior authorization. The Member should present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

- If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. However, an authorization will be issued for the payment of pre-orthodontic visit (D8660), which includes treatment plan, radiographs, and/or photos, records and diagnostic models for full treatment cases only (D8080), at the Provider's contracted rate. This payment will be automatically generated for any case denied for full treatment.

Orthodontic treatment requires the following documentation to show medical necessity:

- Completed ADA Claim Form
- OrthoCad equivalent or diagnostic quality photo's labeled with the member's full name, date photo(s) taken (mm/dd/yyyy), and identify the patients left and right side/or labeled study models with member's full name, Lateral cephalometric radiograph, panorex, or PA x-rays
- Narrative or Rationale including diagnosis/treatment plan (On a case-by-case basis).

Appropriate photographic requirements include:

The below will need to state "Labeled" with the member's full name, date of photo(s) taken (mm/dd/yyyy), and identify the patients left and right side.

- Facial photographs (right and left profiles in addition to a straight-on facial view)
- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

In addition to or in lieu of the above photographic requirement, DentaQuest will accept quality photographs of study models with the following parameters:

The below will need to state "Labeled" with the member's full name, date of photo(s) taken (mm/dd/yyyy), and identify the patients left and right side.

- Occlusal view of the maxillary arch

- Occlusal view of the mandibular arch
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Facial views, straight on and low angle, in occlusion
- Posterior view of models in occlusion

KENTUCKY ORTHODONTIC CRITERIA FOR MEDICAL NECESSITY	YES	NO
Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
Demonstrates a large anterior -posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III)		
Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar).		
Demonstrates a medically documented speech pathology resulting from the malocclusion		
Significant posterior open bites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
Except for third molars, demonstrates an impacted tooth that will not erupt into the arch without orthodontic or surgical intervention and Shows a documented pathology; or Poses a significant threat to the integrity of the remaining dentition or to the health of the patient.		
Overjet in excess of 8 mm.		
Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures and does not include simple loss of teeth with no other affects		
Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation		
Significant facial asymmetry requiring a combination orthodontic and orthographic surgery for correction.		
Dentition exhibits a profound impact from a congenital or developmental disorder.		

Codes for Kentucky;

- D8080- Comprehensive treatment
- D8660 – Records for denied cases only – 1 per Lifetime
- D8670 – One adjustment is allowed after six months per member
- D8999 - D8999 is for COC/Transfer cases or by demonstration of medical necessity. Providers may bill D8999 for retention.

A Provider may not bill D8210 (Removable Appliance Therapy) or D8220 (Fixed Appliance Therapy) after or on the same day as comprehensive orthodontics (D8080). If a Provider performs a D8210 or D8220 after or on the same day of initiating Comprehensive Orthodontics (D8080), then the procedure is considered part of the comprehensive orthodontic therapy.

Cleft and orthographic surgery cases are excluded from the "treatment in full policy" and are considered on a case-by-case basis.

DentaQuest will make the final determination for orthodontic treatment upon receipt of all the work-up materials.

General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the recipient's mouth. The Member must be eligible on the first date of service. If the Member loses eligibility during treatment, the full treatment will not be covered/paid.

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

The provider will need to submit a

Fax or mail claims on a 2012 or later approved ADA claim form with the date of services (banding date) filled in.

The Fax number is: 262-834-3589

The Mailing address is:

DentaQuest

PO Box 2906

Milwaukee, WI 53201-2906

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Providers cannot bill for the replacement of removable orthodontic appliances and post-treatment maintenance retainers that are lost or damaged.

Please notify DentaQuest should the patient discontinue treatment for any reason

Orthodontic Payment Information

- Initial payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, de-banding, 1 set of retainers, and 12 months of retainer adjustments
- Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit a claim for a periodic treatment visits (Code D8670) after six months of treatment to receive the final payment for orthodontics. At the end of treatment, Providers may bill for D8999 for retention.
- The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and one (1) periodic orthodontic treatment visits (D8670) six months after banding. Members may not be billed for broken, repaired, or replacement of brackets or wires.
- Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the UM consultant, this will be applied for all denied cases. Please do not submit separate claims for these procedures.

Refer to the table for Benefit Limitations and the Required Documentation for all of the Orthodontic Codes for Kentucky.

Continuation of Care: The following documentation is required to accompany all prior authorization requests for orthodontic Continuation of Care cases that transfer from one provider OR when a member moves between Plans during treatment.

Required Documentation:

- DentaQuest "Continuation of Care Form" – (see Appendix A).
- 2012 or newer ADA claim form listing services to be rendered.

- A copy of Member's prior approval from previous Managed Care Organizations including the total approved case fee, banding fee, and periodic orthodontic treatment fees.

If a copy of the previous approval is not available, or the patient was previously approved through a private arrangement or commercial plan, you will need to provide diagnostic records (original records are preferred, but progress records will be accepted) in order for DentaQuest to make a determination on the Continuation of Care.

Continuity of Care Process:

Ortho Continuation/Transfer of Care: Member undergoing orthodontic transfers to from another MCO.

DentaQuest will still need to assess medical necessity for continuation of treatment using established orthodontic COC protocol.

- Member under care by a DQ Network Provider: Unlike other dental services, the ortho transition of care would need to be arranged on the front-end to ensure that the State's definition of medical necessity is met and that payment mechanisms are properly outlined.

The provider must submit the following up-front to allow for DQ to validate medical necessity and payment structure for the case:

- Ortho COC Form (completed)
- Completed ADA form with treatment plan
- Copy of the member's prior approval letter with the total case fee and payment structure
- Detailed payment history
- Lateral cephalometric radiograph, panorex, or PA x-rays
- Diagnostic quality progress photo's labeled with the member's full name, date photo(s) taken (mm/dd/yyyy), and identify the patients left and right side

If the member has transferred to a DQ network provider, DQ will assess provided information to ensure that new ortho provider's payment is calculated against payments already made by the prior MCO during ortho treatment under prior provider.

If the member is remaining with an existing DQ network provider for ortho treatment, DQ will also ensure that the provider's payment is calculated against payments already made by the prior MCO.

COC for Member Transfer:

Non-Ortho Continuation/Transfer of Care: Member transfers from another MCO. If they have an existing authorization for dental treatment from their prior MCO, Humana Healthy Horizons or DQ will honor that existing authorization for 90 days from the point of the member's effective date under Humana.

- Member under care by a DQ Network Provider: The provider can treat the member. All services prior approved by another MCO will be honored by DQ as long as the treatment is rendered within 90 days of the member's transfer to Humana.

The provider will only need to submit a copy of the prior MCO's authorization determination along with their claim to DQ and use the keyword "TOC" for transfer of care within the notes field. This keyword will allow the claim to suspend for review so that DQ can validate that the services had been prior authorized. If all services rendered were substantiated against the prior MCO's authorization, the claim will process and pay completely.

Any services rendered that were not authorized by the member's prior MCO will require retrospective review by DQ to substantiate medical necessity. If documentation to support the medical necessity of these additional services was not provided, the associated services would deny with indication that additional documentation was needed for review.

- **Member under care by a Non DQ Network Provider (if approved by Humana Healthy Horizons):** The provider can treat the member. All services prior approved by another MCO will be honored by DQ as long as the treatment is rendered within 90 days of the member's transfer to Humana Healthy Horizons.

The provider will only need to submit a copy of the prior MCO's authorization determination along with their claim to DQ and use the keyword "TOC" for transfer of care within the notes field. This keyword will allow the claim to suspend for review first to set our processing system to allow an out of network provider. Once that status is set, the claim will undergo further review so that DQ can validate that the services had been prior authorized. If all services rendered were substantiated against the prior MCO's authorization, the claim will process and pay completely.

Any services rendered that were not authorized by the member's prior MCO will require retrospective review by DQ to substantiate medical necessity. If documentation to support the medical necessity of these additional services was not provided, the associated services would deny with indication that additional documentation was needed for review.

DQ will alert our Provider Engagement team to the situation so that provider recruitment can occur.

17.00 Cultural Competency Program

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

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

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

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

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Provider Services Department at (800) 508-6787 or via e-mail at: denelig.benefits@DentaQuestusa.com.

18.00 Reimbursement of Services Rendered

Reimbursement will only occur for services that are medically necessary and do not duplicate another provider's service. "Medically necessary" is defined as services that meet the following conditions:

- necessary to protect life, prevent significant illness or significant disability or alleviate severe pain
- individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- consistent with generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide

In addition, the services must meet the following criteria:

- The services cannot be experimental or investigational; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved care, goods, or services do not, in itself, make such care, goods or services medically necessary or a covered service.

19.00 Language and Translation Services

At no cost to the provider or member, interpreter services are available to members who are hearing impaired or non-English speaking. Information about language and translation services is available by contacting Humana Healthy Horizons Member or Provider Services.

Services include:

- TDD/TYY Services for those with a hearing impairment
 - AT&T Relay Service in English: **1-800-855-2880**
 - AT&T Relay Service in Spanish: **1-800-855-2884**
 - AT&T Relay Service for associates contacting hearing impaired members: **1-800-848-0229**
- Video Relay Services
 - Visit <http://www.fcc.gov/encyclopedia/trs-providers> for a list of Video Relay Service Providers.

Services provided at or by public health departments or public entities: public entities, such as public health departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

20.00 Provider Medicaid Requirements

The Department for Medicaid Services (DMS) only contracts with providers or entities qualified under 907 KAR 1:671 and 907 KAR 1:672 and approved by DMS to participate. DMS reserves the right to approve or reject a contract with any prospective provider.

Providers are able to review what is needed to enroll online at: <http://chfs.ky.gov/dms/provenr>

Providers may find all forms needed at: <http://chfs.ky.gov/dms/provenr/forms.htm>

NPI verifications may be found at: <https://npiregistry.cms.hhs.gov/registry/>

APPENDIX A - Attachments

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies, please visit our website at www.DentaQuest.com/Kentucky. Once you have entered the website, click "Login" located at the top right corner. You will then be able to log in using your User ID and Password. Once logged in, select the link "Related Documents" to access the following resources:

- Acknowledgment of Disclosure & Acceptance of Member Financial Responsibility Consent Form
- Authorization for Dental Treatment
- Dental Claim Form
- Direct Deposit Form
- HIPAA Companion Guide
- Initial Clinical Exam
- Instructions for Dental Claim Form
- Medical and Dental History
- OrthoCAD Submission Form
- Orthodontic Continuation of Care Submission Form
- Provider Change Form
- Recall Examination Form
- Request for Transfer of Records

APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org

Association for Electronic Health Care Transactions (AFEHCT)

- A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/.
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

KY Orthodontic Continuation of Care Submission Form

Date: _____

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN or ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Months of Active Treatment Completed:	Months of Active Treatment Remaining:

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE BETWEEN MEDICAID PLANS

- ☐ Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different Medicaid program/vendor.
- Required for submission:**
- ☐ Completed ADA form for preauthorization of CDT Code **D8999**.
 - ☐ Copy of original Medicaid Prior Authorization for Comprehensive Orthodontic Treatment (Prior Authorization from Medicaid program/vendor for Comprehensive Orthodontic Treatment approved prior to initiation of orthodontic treatment).

****If required information above is cannot be provided, the case will be reviewed as outlined below.***

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE FROM NON-MEDICAID TO MEDICAID

- ☐ Member initiated treatment while covered by a **NON-Medicaid** program/vendor (FFS or Commercial Insurance plan) OR Self-Pay and Member is now covered by a **Medicaid** program/vendor with the same OR different Provider.
- Required for submission:**
- ☐ Completed ADA form for preauthorization of CDT Code **D8999**.
 - ☐ Diagnostic records (a copy of the original study models/OrthoCad equivalent and/or a complete set of diagnostic photographs and/or a panorex film). Progress records will be accepted if original records are not available. Documentation should demonstrate qualifying criteria for severe handicapping malocclusion.

CHANGES THAT DO NOT HAVE TO BE SUBMITTED FOR CONTINUATION OF CARE PREAUTHORIZATION

See end of document for full Continuation of Care form for use.

APPENDIX B**Member's Covered Benefits (See Exhibits)**

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members under age 21. Providers with benefit questions should contact DentaQuest's Provider Services Department directly at:

(800) 508-6787, press option 2

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

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

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

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

American Dental Association
211 East Chicago Ave.
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 and any other applicable benefit limitations,
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 that requires prepayment review or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to review which includes prior authorization or prepayment review

DentaQuest Review Process
(For Prior Authorization or Claims that Require Prepayment Review)

IMPORTANT

For procedures where “Review Required” fields indicate “yes” or “Post Service Review”

“Yes” means Prior Authorization is required. This requires that the provider must submit the indicated documentation to show medical necessity.

“Post Service Review” indicates that a Prior Authorization is not required, but Prepayment review is still required, and provider must submit the indicated documentation to show medical necessity. Providers may still submit Prior Authorizations for these services.

The information below explains how and when to submit documentation to DentaQuest. The information refers to the “Review Required,” “Benefit Limitations,” and “Documentation Required” fields in the Benefits Covered tables (Exhibits). In this section, documentation may be requested to be sent prior to beginning treatment or “with claim” after completion of treatment.

See the SAMPLE text below that reflects when documentation is requested:

Review Required	Benefit Limitations	Documentation Required	When to Submit Documentation
Yes	One per 1 Lifetime per patient. PRIOR AUTHORIZATION IS REQUIRED.	Study model or OrthoCad, x-rays	Send documentation prior to beginning treatment
Yes	One per 1 Lifetime per patient per quadrant. PRE-PAYMENT REVIEW REQUIRED.	narrative of medical necessity	Send documentation with claim after treatment

See the SAMPLE text below that reflects when documentation is not requested:

Review Required	Benefit Limitations	Documentation Required	When to Submit Documentation
No	One per 12 Months per patient.		No documentation needed prior to beginning treatment or with claim after treatment

Exhibit A Benefits Covered for Adult Medicaid

Diagnostic services include the oral examination, 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. When individual radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for radiographs is limited to those films 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 good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs 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	21 and older		No	Two of (D0120, D0150) per 1 Calendar year(s) Per Provider. 1 per 6 months - additional allowed based on medical necessity by prior authorization	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140) per 1 Day(s) Per Provider. One of (D0150) per 1 Day(s) Per Provider. Trauma related injuries and acute infection. May only be billed in conjunction with D0220, D0230, D0270, D0272, D0274, D0330, D2330, D2331, D2332, D2335, D7140, D7130, D7210, D7250, D7530, D7910, D9240 Coverage for a limited oral evaluation shall: 1. Be limited to a trauma related injury or acute infection; and 2. Be limited to one (1) per date of service, per recipient, per provider. (b) A limited oral evaluation shall not be covered in conjunction with another service except for: 1. A periapical X-ray; 2. A bitewing X-ray; 3. A panoramic X-ray; 4. Resin, anterior; 5. A simple or surgical extraction; 6. Surgical removal of a residual tooth root; 7. Removal of a foreign body; 8. Suture of a recent small wound; 9. Intravenous sedation; or 10. Incision and drainage of infection.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525..	

Exhibit A Benefits Covered for Adult Medicaid

D0160	detailed and extensive oral evaluation - problem focused, by report	21 and older		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	21 and older		No	One of (D0170, D0171) per 12 Month(s) Per Provider.	
D0171	re-evaluation – post-operative office visit	21 and older		No	One of (D0170, D0171) per 12 Month(s) Per Provider.	

Exhibit A Benefits Covered for Adult Medicaid

D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	
D0190	Screening of a patient	21 and older		No		

Exhibit A Benefits Covered for Adult Medicaid

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0230	intraoral - periapical each additional radiographic image	21 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	Fourteen of (D0220, D0230) per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0210.	
D0270	bitewing - single radiographic image	21 and older		No	Four of (D0270) per 12 Month(s) Per Provider. One of (D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210. Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210. Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210. Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per	

Exhibit A Benefits Covered for Adult Medicaid

					recipient, per provider	
D0277	vertical bitewings - 7 to 8 radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210 1 set per 12 months per member, per provider	
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 24 Month(s) Per Provider.	
D0473	accession of tissue, gross and microscopic exam	21 and older		No		
D0474	accession of tissue, gross and microscopic exam (surgical)	21 and older		No		
D0475	decalcification procedure	21 and older		No		
D0476	special stains for microorganisms	21 and older		No		

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D0477	special stains, not for microorganisms	21 and older		No		
D0478	immunohistochemical stains	21 and older		No		

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Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0479	tissue in-situ hybridization, including interpretation	21 and older		No		
D0482	direct immunofluorescence	21 and older		No		
D0484	consultation on slides prepared elsewhere	21 and older		No		
D0485	consultation, including preparation of slides from biopsy material supplied by referring source	21 and older		No		
D0486	accession of exfoliative cytological smears, microscopic examination, preparation and transmission of written report	21 and older		No		

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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	21 and older		No	One of (D1110) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. 1 per 6 months per member. Additional allowed based on medical necessity by prior authorization.	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.	21 and older		No	One per 12 Month(s) 1 per 6 months per member, per provider	
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	21 and older	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32	No	One of (D1351, D1352) per 48 Month(s) Per patient per tooth. Maximum of 3 times. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Repair, replacement or reapplication of the sealant within the four year period is the responsibility of the dentist.	
D1353	sealant repair – per tooth	21 and older	Teeth 1 - 32, 51 - 82	No	One of (D1353) per 24 months, per patient per tooth.	
D1354	interim caries arresting medicament application - per tooth	21 and older	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32, A-T	No	Two of (D1354) per 6 Month(s) Per patient per tooth.	

Exhibit A Benefits Covered for Adult Medicaid

Reimbursement includes local anesthesia. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. A tooth restored more than once within a six month timeframe by the same provider is subject to being bundled with the first restoration. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

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	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2710	crown - resin-based composite (indirect)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2721	crown - resin with predominantly base metal	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	

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D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
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Exhibit A Benefits Covered for Adult Medicaid

D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2799	Interim Crown	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2799) per 5 years per tooth. 1 per 5 years per tooth	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2920) per 12 months, per tooth 1 per 5 years per tooth	

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D2928	Prefabricated porcelain/ceramic crown – permanent tooth	21 and older	Teeth 1-32 Tooth numbers 1-32, A-T	No	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
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Exhibit A Benefits Covered for Adult Medicaid

D2930	prefabricated stainless steel crown - primary tooth	21 and older	Teeth A – T Tooth numbers 1-32, A-T	No	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2931	prefabricated stainless steel crown- permanent tooth	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2932	prefabricated resin crown	21 and older	Teeth 1 - 32, A - T	No	One of (D2710, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2950	Core buildup, including any pins	21 and older	Teeth 1 - 32, A - T	Post Service Review	One of (D2950, D2954) per 5 years	pre-op x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 – 32 Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	Post- Service Review	Two of (D2951) per 1 Lifetime Per patient per tooth. Limited to permanent molars; used in conjunction with D2160, D2161, D2931, or D2932. Limit of one per tooth per date of service. Permanent molars only (1 2 3 14 15 16 17 18 19 30 31 32). 1 per tooth per date of service and 2 per lifetime per member	
D2954	Prefabricated Post and Core, in addition to crown	21 and older	Teeth 1 - 32, A - T	Post- Service Review	One of (D2950, D2954) per 5 years	pre-op x-ray(s)
D2990	resin infiltration of incipient smooth surface lesions	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	Post- Service Review	One of (D2990) per lifetime, per tooth 2 per tooth per lifetime	

Exhibit A Benefits Covered for Adult Medicaid

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
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	Post-Service Review	One of (D3310) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Tooth numbers 4-5; 12-13; 28-29; 20-21	Post-Service Review	One of (D3320) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Post-Service Review	One of (D3330) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	21 and older	Teeth 1 - 32	Post-Service Review	One of (D3332) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3346	retreatment of previous root canal therapy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Post-Service Review	One of (D3346) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Post-Service Review	One of (D3347) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3348	retreatment of previous root canal therapy - molar	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Post-Service Review	One of (D3348) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3351	apexification/recalcification – initial visit (apical closure/calific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D3351) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3352	apexification/recalcification – interim medication replacement	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D3352) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D3353) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	

Exhibit A Benefits Covered for Adult Medicaid

D3430	retrograde filling - per root	21 and older		Post-Service Review		
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Exhibit A Benefits Covered for Adult Medicaid

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	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period	Perio Charting, pre-op radiographs and narr of med necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity, or drug induced cases. Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period	Perio Charting, pre-op radiographs and narr of med necessity
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment review. Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period	

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D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period	
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period	

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D4249	clinical crown lengthening – hard tissue	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	Post-Service Review	1 per tooth/quadrant per lifetime	
D4263	bone replacement graft – retained natural tooth – first site in quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	1 per site per lifetime	
D4266	guided tissue regeneration - resorbable barrier, per site	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	1 per 36 months	
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	1 per 36 months	
D4270	pedicle soft tissue graft procedure	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	Post-Service Review	1 per Quad, per lifetime	
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T	Post-Service Review	1 per area (tooth) per lifetime	
D4277		21 and older	Tooth numbers 1-32, A-T	Post-Service Review	1 per area (tooth) per lifetime	
D4322	Splint – Intra-coronal	21 and older	Tooth numbers 1-32, A-T	Post-Service Review		
D4323	Splint – Extra-coronal	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers	Post-Service		Perio Charting, pre-op radiographs and narr of

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			1-32, A-T	Review		med necessity
D4341	periodontal scaling and root planing – 1-3 teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR	Post-Service Review	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120. One per 3 months for patients diagnosed with AIDS. There must be radiographic evidence of root surface calculus or significant loss of bone support. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment Requires prior authorization- not to exceed 1 per quadrant, per twelve months, per recipient, per provider	Perio Charting, Pre-op radiographs and narrative of medical necessity

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					review.	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post-Service Review	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of one to three (1-3) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120. There must be radiographic evidence of root surface calculus or significant loss of bone support. Perio Charting and pre-op radiographs must be maintained in the patient record.	Perio Charting, Pre-op radiographs and narrative of medical necessity
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post- Service Review	Only allowed after treatment of periodontal disease; received perio maintenance; or an isolated pocket depth of greater than 5mm – not to be used for generalized perio therapy	Perio Charting required
D4910	Periodontal maintenance	21 and older		No	One of (D4910) per 6 Month(s) Per patient. Only allowable after periodontal therapy has been performed. A narrative required if no history with DentaQuest.	
D4920	Unscheduled dressing change	21 and older	Teeth 1 - 32	No		narr. of med. necessity, pre-op x-ray(s)

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	Complete denture – maxillary	21 and older	Teeth 1 – 32	No	One of (D5110) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5120	Complete denture – mandibular	21 and older	Teeth 1 – 32	No	One of (D5120) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5130	Immediate denture – maxillary	21 and older	Teeth 1 – 32	No	One of (D5130) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5140	Immediate denture – mandibular	21 and older	Teeth 1 – 32	No	One of (D5140) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	21 and older	Teeth 1 – 32	No	One of (D5211) per 60 Month(s) Per patient More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period.	
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	21 and older	Teeth 1 – 32	No	One of (D5212) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older	Teeth 1 – 32	No	One of (D5213) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older	Teeth 1 – 32	No	One of (D5214) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	21 and older	Teeth 1 – 32	No	One of (D5221) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	

Exhibit A Benefits Covered for Adult Medicaid

D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	21 and older	Teeth 1 – 32	No	One of (D5222) per 60 Month(s) Per patient More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period.	
D5282	Removable unilateral partial denture -one piece cast metal - maxillary	21 and older	Teeth 1 – 32	No	One of (D5282) per 12 Month(s) Per patient. Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5283	Removable unilateral partial denture -one piece cast metal - mandibular	21 and older	Teeth 1 – 32	No	One of (D5283) per 12 Month(s) Per patient. Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5284	Removable unilateral partial denture -one piece flexible base - per quadrant	21 and older	Teeth 1 – 32	No	One of (D5284) per 12 Month(s) Per patient. Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5286	Removable unilateral partial denture -one piece resin – per quadrant	21 and older	Teeth 1 - 32	No	One of (D5286) per 12 Month(s) Per patient. Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5410	adjust complete denture - maxillary	21 and older	Upper Arch	No	One per 12 Months(s) Per patient	
D5411	adjust complete denture - mandibular	21 and older	Lower Arch	No	One per 12 Months(s) Per patient	
D5421	adjust partial denture - maxillary	21 and older	Upper Arch	No	One per 12 Months(s) Per patient	
D5422	adjust partial denture - mandibular	21 and older	Lower Arch	No	One per 12 Months(s) Per patient	

Exhibit A Benefits Covered for Adult Medicaid

D5511	repair broken complete denture base, mandibular	21 and older	Teeth 1 – 32	No	One per 12 Months(s) Per patient	
D5512	repair broken complete denture base, maxillary	21 and older	Teeth 1 - 32	No	One per 12 Months(s) Per patient	
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D5520) per 12 Month(s) Per patient per tooth.	
D5611	repair resin partial denture base, mandibular	21 and older		No	Three of (D5611) per 12 Month(s) Per patient.	
D5612	repair resin partial denture base, maxillary	21 and older		No	Three of (D5612) per 12 Month(s) Per patient.	
D5621	repair cast partial framework, mandibular	21 and older		No	Three of (D5621) per 12 Month(s) Per patient.	
D5622	repair cast partial framework, maxillary	21 and older		No	Three of (D5622) per 12 Month(s) Per patient. 1 per 12 months	
D5630	repair or replace broken retentive clasping materials – per tooth	21 and older	Teeth 1 - 32	No	One per 12 Months(s) Per patient	
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D5640) per 12 Month(s) Per Provider per tooth.	

Exhibit A Benefits Covered for Adult Medicaid

D5731	reline complete mandibular denture (direct)	21 and older	Lower Arch		One per 12 Months(s) Per patient	
D5740	reline complete maxillary denture (direct)	21 and older	Upper Arch		One per 12 Months(s) Per patient	
D5750	reline complete maxillary denture (laboratory)	21 and older	Upper Arch	No	One of (D5750) per 12 Month(s) Per patient. Per denture. Not covered within 6 months of placement.	
D5751	reline complete mandibular denture (laboratory)	21 and older	Lower Arch	No	One of (D5751) per 12 Month(s) Per patient. Per denture. Not covered within 6 months of placement.	
D5820	interim partial denture (maxillary)	21 and older		No	One of (D5820) per 12 Month(s) Per patient. 1 per 5 years	
D5821	interim partial denture-mandibular	21 and older		No	One of (D5821) per 12 Month(s) Per patient. 1 per 5 years	

Exhibit A Benefits Covered for Adult Medicaid

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
D5913	nasal prosthesis	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5914	auricular prosthesis	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5932	obturator prosthesis, definitive	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5953	speech aid prosthesis, adult	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5954	palatal augment prosthesis	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5955	palatal lift prosthesis, definitive	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5988	surgical splint	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

Implants and Fixed Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6010	surgical placement of implant body: endosteal implant	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6056	prefabricated abutment – includes modification and placement	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narrative of medical necessity
D6057	custom fabricated abutment – includes placement	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6058	abutment supported porcelain/ceramic crown	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6059	abutment supported porcelain fused to metal crown (high noble metal)	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

D6065	implant supported porcelain/ceramic crown	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6066	implant supported crown - porcelain fused to high noble alloys	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	21 and older	Tooth numbers 1-32, A-T	Yes	Ages 14 and over. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6104	bone graft at time of implant placement	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6190	radiographic/surgical implant index, by report	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

D6211	pontic - cast predominantly base metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6240	pontic - porcelain fused to high noble metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6241	pontic - porcelain fused to predominantly base metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6242	pontic - porcelain fused to noble metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6750	retainer crown - porcelain fused to high noble metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6751	retainer crown - porcelain fused to predominantly base metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6752	retainer crown - porcelain fused to noble metal	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6930	re-cement or re-bond fixed partial denture	21 and older	Tooth numbers 1-32, A-T	Yes	Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

Reimbursement includes local anesthesia and routine post-operative care.

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	21 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 Tooth numbers 1-32, A-T	No	1 per lifetime per tooth per member regardless of provider	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 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 Tooth numbers 1-32, A-T	No	1 per lifetime per tooth per member regardless of provider	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32, A-T	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. 1 per lifetime per tooth per member regardless of provider	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	narr. of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	narr. of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	narr. of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.	pre-operative x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

					regardless of provider	
D7250	surgical removal of residual tooth roots (cutting procedure)	21 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 Tooth numbers 1-32, A-T	Post Service Review	Will not be paid to the dentist or group that removed the tooth. 1 per lifetime per tooth per member regardless of provider	
D7251	Coronectomy	21 and older	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth	pre-operative x-ray(s); narr of medical necessity
D7260	oroantral fistula closure	21 and older		Post Service Review		

Exhibit A Benefits Covered for Adult Medicaid

D7270	Tooth reimplantation	21 and older	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32, A-T	Post Service Review		pre-operative x-ray(s); narr of medical necessity
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review		narr. of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	Post Service Review	Oral surgeons only.	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Adult Medicaid

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant. Usually in preparation for a prosthesis. Be limited to one (1) per quadrant, per lifetime, per recipient; Require a minimum of a four (4) tooth area within the same quadrant.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in an edentulous area.	
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No		
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No		
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	No	Two of (D7471) per 1 Lifetime Per patient. Limited to the removal of exotosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.	
D7472	removal of torus palatinus	21 and older		No	One of (D7472) per 1 Lifetime Per patient.	
D7473	removal of torus mandibularis	21 and older	Per Arch (01, 02, LA, UA)	No	Two of (D7473) per 1 Lifetime Per patient. 1 per quadrant per lifetime	
D7510	incision and drainage of abscess - intraoral soft tissue	21 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		
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	21 and older		No	Shall not pertain to removal of stitches (sutures) or teeth.	
D7880	occlusal orthotic device, by report	21 and older		Yes	One of (D7880) per 1 Lifetime Per patient.	Narrative of medical necessity and photos

Exhibit A Benefits Covered for Adult Medicaid

D7910	suture small wounds up to 5 cm	21 and older		No	Shall not be billed in conjunction with any other surgical procedure. It shall not pertain to repair of surgically induced wounds.	
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Exhibit A Benefits Covered for Adult Medicaid

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7961	frenulectomy – also known as frenectomy or frenotomy – lingual/buccal	21 and older		Post Service Review	One of (D7961, D7962) per 1 Day(s) Per patient. 2 per date of service @ \$167.60 each	
D7962	frenulectomy – also known as frenectomy or frenotomy –	21 and older		Post Service Review	One of (D7961, D7962) per 1 Day(s) Per patient. 2 per date of service @ \$167.60 each	

Exhibit A Benefits Covered for Adult Medicaid

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
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	One of (D9110) per 1 Day(s) Per Provider OR Location. Not allowed with any other services such as panoramic radiographic images (D0330), cephalometric radiographic images (D0340), digital images. 1 per date of service	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Post Service Review	One of (D9222) per 1 Day(s) Per patient. Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Post Service Review	Four of (D9223, D9243) per 1 Day(s) Per patient. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older			Not allowed with D9243.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Post Service Review	One of (D9239) per 1 Day(s) Per patient. Requires Dentists to have anesthesia certification on file in their office for auditing purposes	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Post Service Review	Four of (D9223, D9243) per 1 Day(s) Per patient. Not allowed with D9223. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230. Requires Dentists to have anesthesia certification on file in their office for auditing purposes	narrative of medical necessity

Exhibit A Benefits Covered for Adult Medicaid

D9248	non-intravenous moderate (conscious) sedation	21 and older		Post Service Review	One of (D9248) per 1 Day(s) Per patient. No review required for ages 0-9. Pre-payment is required for ages 10-20. Requires Dentists to have anesthesia certification on file in their office for auditing purposes	narrative of medical necessity
D9410	house/extended care facility call	21 and older		No	One of (D9410) per 1 Day(s) Per Provider OR Location per tooth.	
D9420	hospital or ambulatory surgical center call	21 and older		No	One of (D9420) per 1 Day(s) Per Provider OR Location. No other procedures may be billed in conjunction with D9420. Not applicable for nursing home visits (D0150 or D9110). Can not bill conjunctively.	
D9610	therapeutic drug injection, by report	21 and older		Post Service Review	One of (D9610, D9612) per 1 Day(s) Per patient. Oral surgeons only.	narrative of medical necessity

Exhibit A Benefits Covered for Adult Medicaid

D9612	therapeutic drug injection - 2 or more medications by report	21 and older		Post-Service Review	One of (D9610, D9612) per 1 Day(s) Per patient. Oral surgeons only.	narrative of medical necessity

Exhibit A Benefits Covered for Adult Medicaid

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9944	occlusal guard – hard appliance, full arch	21 and older		Yes	One of (D9944, D9945, D9946) per 24 Month(s)	narrative of medical necessity
D9945	occlusal guard – soft appliance, full arch	21 and older		Yes	One of (D9944, D9945, D9946) per 24 Month(s)	narrative of medical necessity
D9946	occlusal guard – hard appliance, partial arch	21 and older		Yes	One of (D9944, D9945, D9946) per 24 Month(s)	narrative of medical necessity
D9986	Missed Appointment	21 and older		No	One of (D9986, D9987) per 1 Day(s) Per patient. per record of broken or missed appointment. Not allowable in conjunction with any other benefit for the date of service filed. Documentation within patient record must support that a scheduled appointment was missed or broken.	
D9987	Cancelled Appointment	21 and older		No	One of (D9986, D9987) per 1 Day(s) Per patient. per record of broken or missed appointment. Not allowable in conjunction with any other benefit for the date of service filed. Documentation within patient record must support that a scheduled appointment was missed or broken.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Diagnostic services include the oral examination, 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. When individual radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for radiographs is limited to those films 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 good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs 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	0-20		No	Two of (D0120, D0150) per 1 Calendar year(s) Per Provider. 1 per 6 months - additional allowed based on medical necessity by prior authorization.	
D0140	limited oral evaluation-problem focused	0-20		No	One of (D0120, D0140, D0150) per 1 Day(s) Per Provider. Trauma related injuries and acute infection. May only be billed in conjunction with D0220, D0230, D0270, D0272, D0274, D0330, D2330, D2331, D2332, D2335, D7140, D7130, D7210, D7250, D7530, D7910, D9240 Coverage for a limited oral evaluation shall: 1. Be limited to a trauma related injury or acute infection; and 2. Be limited to one (1) per date of service, per recipient, per provider. (b) A limited oral evaluation shall not be covered in conjunction with another service except for: 1. A periapical X-ray; 2. A bitewing X-ray; 3. A panoramic X-ray; 4. Resin, anterior; 5. A simple or surgical extraction; 6. Surgical removal of a residual tooth root; 7. Removal of a foreign body; 8. Suture of a recent small wound; 9. Intravenous sedation; or 10. Incision and drainage of infection.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	Two of (D0145, D0150) per 1 Calendar year(s) Per Provider. Oral evaluation for a patient under three years of age and counseling with primary caregiver. Limit against D0150. Under 3 years of age - 1 per 6 months	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	
D0160	detailed and extensive oral evaluation - problem focused, by report	0-20		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	0-20		No	One of (D0170, D0171) per 12 Month(s) Per Provider.	
D0171	re-evaluation – post-operative office visit	0-20		No	One of (D0170, D0171) per 12 Month(s) Per Provider.	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	One of (D0150, D0160, D0180) per 12 Month(s) Per Provider. Cannot be billed on the same day as D0120, D0140, D1510, D1515, D1520, D1525.	
D0190	Screening of a patient	0-20		No	Two of (D0190) per 1 Calendar year(s) Per Provider.	
D0191	Assessment of a patient	0-20		No	Two of (D0191) per 1 Calendar year(s) Per Provider.	
D0210	intraoral - complete series of radiographic images	0-20		No	One of (D0210) per 12 Month(s) Per Provider OR Location. One per patient per provider or dental group Limited to one (1) per twenty-four (24) month period, per recipient, per provider. Periapical and bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0220	intraoral - periapical first radiographic image	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Fourteen of (D0220, D0230) per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0210.	
D0230	intraoral - periapical each additional radiographic image	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Fourteen of (D0220, D0230) per 12 Month(s) Per Provider. Not to be billed in the same 12 months as a D0210.	
D0270	bitewing - single radiographic image	0-20		No	Four of (D0270) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210.	
D0272	bitewings - two radiographic images	0-20		No	Two of (D0270, D0272, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210. Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	
D0273	bitewings - three radiographic images	0-20		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210. Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	
D0274	bitewings - four radiographic images	0-20		No	One of (D0270, D0272, D0274) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider	
D0277	vertical bitewings - 7 to 8 radiographic images	0-20		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per Provider. There should be no more than 4 bitewing films in a 12 month period. Not to be billed in the same 12 months as D0210	
D0330	panoramic radiographic image	0-5		No	One of (D0330) per 24 Month(s) Per Provider. Authorization Requirement for ages 5 and under. Narrative of medical necessity for ages 0-5.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0330) per 24 Month(s) Per Provider. No Authorization required for ages 6-20.	
D0340	cephalometric radiographic image	0-20		No	One of (D0340) per 1 Day(s) Per Provider. 1 per 24 months per member, per provider	
D0472	accession of tissue, gross examination	0-20		No		
D0473	accession of tissue, gross and microscopic exam	0-20		No		
D0474	accession of tissue, gross and microscopic exam (surgical)	0-20		No		

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0475	decalcification procedure	0-20		No		
D0476	special stains for microorganisms	0-20		No		
D0477	special stains, not for microorganisms	0-20		No		
D0478	immunohistochemical stains	0-20		No		
D0479	tissue in-situ hybridization, including interpretation	0-20		No		
D0482	direct immunofluorescence	0-20		No		
D0484	consultation on slides prepared elsewhere	0-20		No		
D0485	consultation, including preparation of slides from biopsy material supplied by referring source	0-20		No		
D0486	accession of exfoliative cytological smears, microscopic examination, preparation and transmission of written report	0-20		No		

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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	14 - 20		No	Two of (D1110) per 12 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	Two of (D1120) per 12 Month(s) Per patient. 1 per 6 months per member. Additional allowed based on medical necessity by prior authorization	
D1206	topical application of fluoride varnish	0-20		No	Two of (D1206, D1208) per 12 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-20		No	Two of (D1206, D1208) per 12 Month(s) Per patient.	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.	12-20		No	One per 12 Month(s) 1 per 6 months per member, per provider	
D1351	sealant - per tooth	5-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers: 3, 14, 19, 30 2, 15, 18, 31	No	One of (D1351, D1352) per 48 Month(s) Per patient per tooth. Maximum of 3 times. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Repair, replacement or reapplication of the sealant within the four year period is the responsibility of the dentist. Limited to six (6) and twelve (12) year molars: 6 year molars are #3, #14, #19 and #30 12 year molars are #2, #15, #18, #31 once every four (4) years with a lifetime limit of three (3) sealants per tooth	
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth	5-20	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32	No	Limited to under 21 only One of (D1351, D1352) per 48 Month(s) Per patient per tooth. Maximum of 3 times. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Repair, replacement or reapplication of the sealant within the four year period is the responsibility of the dentist.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D1353	sealant repair – per tooth	5-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32	No	One of (D1353) per 24 months, per patient per tooth.	
D1354	interim caries arresting medicament application - per tooth	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T	No	Two of (D1354) per 6 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1520, D1525) per 12 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1516	space maintainer --fixed--bilateral, maxillary	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1520, D1525) per 12 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1526	space maintainer --removable--bilateral, maxillary	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1556	Removal of fixed unilateral space maintainer – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1557	Removal of fixed bilateral space maintainer – maxillary	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517,	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1558	Removal of fixed bilateral space maintainer – mandibular	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		Two of (D1510, D1515, D1516, D1517, D1520, D1525, D1526, D1527) per 12 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Reimbursement includes local anesthesia. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. A tooth restored more than once within a six month timeframe by the same provider is subject to being bundled with the first restoration. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

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	0-20	Teeth 1 - 32, A – T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A – T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A – T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A – T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M – R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

			Surface code M, O, D, B, L, F, I			
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M – R Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R Tooth numbers 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface. 1 per 5 years	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

			1-32, A-T Surface code M, O, D, B, L, F, I			
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2710, D2721) per 12 Month(s) Per patient per tooth, per surface.	
D2710	crown - resin-based composite (indirect)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2721	crown - resin with predominantly base metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	No	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					1 per 5 years per tooth	
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2792	crown - full cast noble metal	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933, D2721, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2928) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2799	Interim Crown	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	Yes	One of (D2799) per 5 years per tooth.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 5, 12 - 21, 28 - 32 Tooth numbers 1-32, A-T	No	One of (D2920) per tooth, per 12 months 1 per 5 years per tooth	
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 1-32 Tooth numbers	No	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

			1-32, A-T		1 per 5 years per tooth	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A – T Tooth numbers 1-32, A-T	No	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D2390, D2710, D2721, D2751, D2930, D2931, D2932, D2933) per 60 Month(s) Per patient per tooth. 1 per 5 years per tooth	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	1 per 5 years per tooth	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	No	Once per tooth per 12 month per member. Ages 0 - 11	
D2950	Core buildup, including any pins	0-20	Teeth 1 – 32 1-32, A-T	Post-Service Review	One of (D2950, D2954) per 5 years change to adult and child 1/1/2023 no prior auth required.	pre-op x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 – 32 Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	Post Service Review	Two of (D2951) per 1 Lifetime Per patient per tooth. Limited to permanent molars; used in conjunction with D2160, D2161, D2931, or D2932. Limit of one per tooth per date of service. Permanent molars only (1 2 3 14 15 16 17 18 19 30 31 32). 1 per tooth per date of service and 2 per lifetime per member	pre-op x-ray(s)
D2954	Prefabricated Post and Core, in addition to crown	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post-Service Review	One of (D2950, D2954) per 5 years change to adult and child 1/1/2023 no prior auth required.	pre-op x-ray(s)
D2990	resin infiltration of incipient smooth surface lesions	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T Tooth numbers 1-32, A-T	Post-Service Review	One of (D2990) per lifetime, per tooth 2 per tooth per lifetime	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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
D3110	pulp cap - direct (excluding final restoration)	0-20	Teeth 1 - 32, A - T	Post Service Review		
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	Post Service Review		
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	Post Service Review	Shall not be billed in conjunction with D3310, D3320, and D3330 on the same day. 1 per tooth per lifetime	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	Post Service Review		
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth 1 - 32, A - T	Post Service Review		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	Post Service Review	One of (D3310) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Post Service Review	One of (D3320) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Post Service Review	One of (D3330) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record.	
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	0-20	Teeth 1 - 32	Post Service Review	One of (D3332) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D3346	retreatment of previous root canal therapy - anterior	0-20	Teeth 6 - 11, 22 - 27	Post Service Review	One of (D3346) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Post Service Review	One of (D3347) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3348	retreatment of previous root canal therapy - molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Post Service Review	One of (D3348) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review	One of (D3351) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3352	apexification/recalcification – interim medication replacement	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review	One of (D3352) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review	One of (D3352) per 1 Lifetime Per patient per tooth. Pre and post-operative x-rays should be maintained within the patient record	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 – 27 Tooth numbers 1-32, A-T	Post Service Review	One of (D3410) per 1 Lifetime Per patient per tooth.	
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Post Service Review	One of (D3421) per 1 Lifetime Per patient per tooth.	
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Post Service Review	One of (D3425) per 1 Lifetime Per patient per tooth.	
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 – 32 Tooth numbers 1-32, A-T	Post Service Review	One of (D3426) per 1 Lifetime Per patient per tooth.	
D3430	retrograde filling - per root	0-20	Teeth numbers 1-32, A-T	Post Service Review	1 per tooth per lifetime	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment review.	Perio Charting, pre-op radiographs and narr of med necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity, or drug induced cases. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment review.	Perio Charting, pre-op radiographs and narr of med necessity
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4210, D4211, D4212) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Limited to patients with gingival overgrowth due to congenital, heredity or drug induced causes. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment review.	
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant	
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4240, D4241) per 12 Month(s) Per patient per quadrant.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D4249	clinical crown lengthening – hard tissue	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	Post Service Review	1 per tooth/quadrant per lifetime	
D4263	bone replacement graft – retained natural tooth – first site in quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	1 per site per lifetime	
D4266	guided tissue regeneration - resorbable barrier, per site	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	1 per 36 months	
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	1 per 36 months	
D4270	pedicle soft tissue graft procedure	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	Post Service Review	1 per Quad, per lifetime	
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T	Post Service Review	1 per Quad, per lifetime 1 per area (tooth) per lifetime	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D4277	Combined connective tissue and double pedicle graft, per tooth	0-20	Teeth 1-32 Tooth numbers 1-32, A-T	Post Service Review	1 Per Tooth, per lifetime	
D4322	Splint – Intra-coronal	0-20	Tooth numbers 1-32, A-T	Post Service Review	1 per Tooth, per lifetime	
D4323	Splint – Extra-coronal	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Tooth numbers 1-32, A-T	Post Service Review	1 per Tooth, per lifetime	
D4341	periodontal scaling and root planing – 1-3 teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120. One per 3 months for patients diagnosed with AIDS. There must be radiographic evidence of root surface calculus or significant loss of bone support. Perio Charting, pre-op radiographs and narrative of medical necessity with claim for prepayment review. Requires prior authorization- not to exceed 1 per quadrant, per twelve months, per recipient, per provider	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Post Service Review	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of one to three (1-3) teeth in the affected quadrant. Cannot bill in conjunction with D1110 or D1120. There must be radiographic evidence of root surface calculus or significant loss of bone support. Perio Charting and pre-op radiographs must be maintained in the patient record.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	0-20		Post Service Review	One of (D4355) per 36 Month(s) Per patient. Not allowable after D4341 or D4342. Not to be completed on the same day as D0150.	narr. of med. necessity, pre-op x-ray(s)
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review	One per tooth, per 6 months, Only allowed after treatment of periodontal disease; received perio maintenance; or an isolated pocket depth of greater than 5mm – not to be used for generalized perio thearopy Prior authorization required - only allowed after treatment of periodontal disease; received perio maintenance; or an isolated pocket depth of greater than 5mm – not to be used for generalized perio thearopy.	Perio Charting required
D4910	periodontal maintenance procedures	0-20		No	One of (D4910) per 6 Month(s) Per patient. Only allowable after periodontal therapy has been performed. A narrative required if no history with DentaQuest.	
D4920	Unscheduled dressing change	0-20	Teeth 1 - 32	No		narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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

BILLING AND REIMBURSEMENT FOR CAST CROWNS CAST POST & CORES & LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	Complete denture – maxillary	0-20	Teeth 1 – 32	No	One of (D5110) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5120	Complete denture – mandibular	0-20	Teeth 1 – 32	No	One of (D5120) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5130	Immediate denture – maxillary	0-20	Teeth 1 – 32	No	One of (D5130) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5140	Immediate denture – mandibular	0-20	Teeth 1 – 32	No	One of (D5140) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					period	
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5211) per 60 Month(s) Per patient More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period.</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5212) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5213) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5214) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more</p>	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					<p>than 1 needed in 5 year period</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5221) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	0-20	Teeth 1 – 32	No	<p>One of (D5222) per 60 Month(s) Per patient. More frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period.</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5282	Removable unilateral partial denture -one piece cast metal - maxillary	0-20	Teeth 1 – 32	No	<p>One of (D5282) per 12 Month(s) Per patient.</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5283	Removable unilateral partial denture -one piece cast metal - mandibular	0-20	Teeth 1 – 32	No	<p>One of (D5283) per 12 Month(s) Per patient.</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5284	Removable unilateral partial denture -one piece flexible base - per quadrant	0-20	Teeth 1 – 32	No	<p>One of (D5284) per 12 Month(s) Per patient.</p> <p>Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period</p>	
D5286	Removable unilateral partial denture -one piece resin – per quadrant	0-20	Teeth 1 - 32	No	<p>One of (D5286) per 12 Month(s) Per patient.</p>	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period	
D5410	adjust complete denture - maxillary	0-20	Upper Arch	No	One per 12 Months(s) Per patient	
D5411	adjust complete denture - mandibular	0-20	Lower Arch	No	One per 12 Months(s) Per patient	
D5421	adjust partial denture - maxillary	0-20	Upper Arch	No	One per 12 Months(s) Per patient	
D5422	adjust partial denture - mandibular	0-20	Lower Arch	No	One per 12 Months(s) Per patient	
D5511	repair broken complete denture base, mandibular	0-20	Teeth 1 – 32	No	One per 12 Months(s) Per patient	
D5512	repair broken complete denture base, maxillary	0-20	Teeth 1 - 32	No	One per 12 Months(s) Per patient	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D5520) per 12 Month(s) Per patient per tooth. 1 per 12 months	
D5611	repair resin partial denture base, mandibular	0-20		No	Three of (D5611) per 12 Month(s) Per patient.	
D5612	repair resin partial denture base, maxillary	0-20		No	Three of (D5612) per 12 Month(s) Per patient.	
D5621	repair cast partial framework, mandibular	0-20		No	Three of (D5621) per 12 Month(s) Per patient.	
D5622	repair cast partial framework, maxillary	0-20		No	Three of (D5622) per 12 Month(s) Per patient. 1 per 12 months	
D5630	repair or replace broken retentive clasping materials – per tooth	0-20	Teeth 1 - 32	No	One of (D5630) per 12 Month(s) Per Provider per tooth 1 per 12 months	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	No	One of (D5640) per 12 Month(s) Per Provider per tooth. 1 per 12 months	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D5731	reline complete mandibular denture (direct)		Lower Arch		One per 12 Months(s) Per patient	
D5740	reline complete maxillary denture (direct)		Upper Arch		One per 12 Months(s) Per patient	
D5750	reline complete maxillary denture (laboratory)	0-20	Upper Arch	No	One of (D5750) per 12 Month(s) Per patient. Per denture. Not covered within 6 months of placement. 1 per 12 months	
D5751	reline complete mandibular denture (laboratory)	0-20	Lower Arch	No	One of (D5751) per 12 Month(s) Per patient. Per denture. Not covered within 6 months of placement. 1 per 12 months	
D5820	interim partial denture (maxillary)	0-20		No	One of (D5820) per 12 Month(s) Per patient. 1 per 5 years	
D5821	interim partial denture-mandibular	0-20		No	One of (D5821) per 12 Month(s) Per patient. 1 per 5 years	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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
D5913	nasal prosthesis	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5914	auricular prosthesis	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narrative of medical necessity
D5919	facial prosthesis	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5932	obturator prosthesis, definitive	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5934	mandibular resection prosthesis with guide flange	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5952	speech aid prosthesis, pediatric	0-13		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5953	speech aid prosthesis, adult	14 - 20		Yes	Ages 14 and over.	narr. of med. necessity, pre-op x-ray(s)
D5954	palatal augment prosthesis	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5955	palatal lift prosthesis, definitive	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5988	surgical splint	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes	Covered for Prosthodontists only. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children’s Medicaid and CHIP

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Exhibit B Benefits Covered for Children's Medicaid and CHIP

Reimbursement includes local anesthesia and routine post-operative care.

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

Implants and Fixed Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6010	surgical placement of implant body: endosteal implant	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6056	prefabricated abutment – includes modification and placement	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narrative of medical necessity
D6057	custom fabricated abutment – includes placement	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6058	abutment supported porcelain/ceramic crown	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6059	abutment supported porcelain fused to metal crown (high noble metal)	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D6065	implant supported porcelain/ceramic crown	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6066	implant supported crown - porcelain fused to high noble alloys	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x- rays with claim for prepayment review prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6103	bone graft for repair of peri-implant defect – does not include flap entry and closure	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6104	bone graft at time of implant placement	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D6190	radiographic/surgical implant index, by report	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime	narr. of med. necessity, pre-op x-ray(s)
D6211	pontic - cast predominantly base metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6240	pontic - porcelain fused to high noble metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6241	pontic - porcelain fused to predominantly base metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6242	pontic - porcelain fused to noble metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6750	retainer crown - porcelain fused to high noble metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review. 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6751	retainer crown - porcelain fused to predominantly base metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review 1 per 5 years	narr. of med. necessity, pre-op x-ray(s)
D6752	retainer crown - porcelain fused to noble metal	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

					1 per 5 years	
D6930	re-cement or re-bond fixed partial denture	14 - 20	Tooth numbers 1-32, A-T	Yes	One per tooth per 60 months. Narrative of medical necessity and pre-op x-rays with claim for prepayment review.	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32, A-T	No	1 per lifetime per tooth per member regardless of provider	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32, A-T	No	1 per lifetime per tooth per member regardless of provider	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32, A-T	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. 1 per lifetime per tooth per member regardless of provider	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82 Tooth numbers 1-32, A-T	Post Service Review	1 per lifetime per tooth per member regardless of provider	pre-operative x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32, A-T	Post Service Review	Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. 1 per lifetime per tooth per member regardless of provider.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS Tooth numbers 1-32, A-T	Post Service Review	Will not be paid to the dentist or group that removed the tooth. 1 per lifetime per tooth per member regardless of provider	
D7252	coronectomy – intentional partial tooth removal	0-20		Post Service Review	Once per tooth, per lifetime	
D7260	oroantral fistula closure	0-20		No		
D7270	Tooth reimplantation	0-20	Teeth 1 - 32, 51 – 82 Tooth numbers 1-32, A-T	No		pre-operative x-ray(s); narr of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 – 32 Tooth numbers 1-32, A-T	Post Service Review	Per 907 KAR 1:026 Coverage of surgical access of an unerupted tooth shall: (a) Be limited to exposure of the tooth for orthodontic treatment; and (b) Require prepayment review.	narrative of medical necessity
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	Oral surgeons only.	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant. Usually in preparation for a prosthesis. Be limited to one (1) per quadrant, per lifetime, per recipient; Require a minimum of a four (4) tooth area within the same quadrant.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in an edentulous area.	
D7410	radical excision - lesion diameter up to 1.25cm	0-20		No		
D7411	excision of benign lesion greater than 1.25 cm	0-20		No		
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA) Arch number 01, 02	No	Two of (D7471) per 1 Lifetime Per patient. Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.	
D7472	removal of torus palatinus	0-20		No	One of (D7472) per 1 Lifetime Per patient.	
D7473	removal of torus mandibularis	0-20	Per Arch (01, 02, LA, UA)	No	Two of (D7473) per 1 Lifetime Per patient. 1 per quadrant per lifetime	
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-20		No	Shall not pertain to removal of stitches (sutures) or teeth.	
D7880	occlusal orthotic device, by report	0-20		Yes	One of (D7880) per 1 Lifetime Per patient.	Narrative of medical necessity and photos

Exhibit B Benefits Covered for Children's Medicaid and CHIP

D7910	suture small wounds up to 5 cm	0-20		No	Shall not be billed in conjunction with any other surgical procedure. It shall not pertain to repair of surgically induced wounds.	
D7961	Buccal/Labial Frenectomy	0-20		Post Service Review	Two Per date of service	Narrative of medical necessity and photos
D7962	Lingual Frenectomy	0-20		Post Service Review	Two per date of service 2 per date of service @ \$167.60 each	Narrative of medical necessity and photos

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient. Cephalogram and/or photos are optional.	Study Models, pan or peri xrays, narr/treatment plan
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	Two of (D8210, D8220) per 12 Month(s) Per patient. This appliance is to be used to control harmful habits. Cephalogram and/or photos are optional. Requires prior authorization	Study Models, pan or peri xrays, narr/treatment plan
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	Two of (D8210, D8220) per 12 Month(s) Per patient. This appliance is to be used to control harmful habits. Cephalogram and/or photos are optional. Requires prior authorization	Study Models, pan or peri xrays, narr/treatment plan
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	One of (D8660) per 1 Lifetime Per patient. Used to pay for records. Final records will be paid only if member is age 20 and under and still eligible for benefits on date of service. Member cannot be billed for final records. Requires prior authorization - and only if individual ultimately not approved for orthodontic treatment. Age 0 - 21 only	
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 6 Month(s) Per patient. 6 month payment. Requires prior authorization. Age 0 - 21 only	
D8698	Re-cement or Re-bond fixed retainer - maxillary	0-20		No	One of (D8698) per 12 Month(s) Per patient.	
D8699	Re-cement or Re-bond fixed retainer - mandibular	0-20		No	One of (D8699) per 12 Month(s) Per patient.	
D8701	Repair of fixed retainer, includes reattachment - maxillary	0-20		No	One of (D8701) per 12 Month(s) Per patient. 1 per 4 years	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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

D8702	Repair of fixed retainer, includes reattachment - mandibular	0-20		No	One of (D8702) per 12 Month(s) Per patient. 1 per 4 years	
D8703	Replacement of lost or broken retainer - maxillary	0-20		No	One of (D8703) per 12 Month(s) Per patient. 1 per 4 years	
D8704	Replacement of lost or broken retainer	0-20		No	One of (D8704) per 12 Month(s) Per patient. 1 per 4 years	
D8999	unspecified orthodontic procedure, by report	0-20		Yes	Two of (D8999) per 1 Lifetime Per patient. D8999 payable with completion of treatment. Second D8999 payable when medically necessary. Requires prior authorization. Age 0 - 21 only	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	One of (D9110) per 1 Day(s) Per Provider OR Location. Not allowed with any other services such as panoramic radiographic images (D0330), cephalometric radiographic images (D0340), digital images. 1 per date of service	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Post Service Review	One of (D9222) per 1 Day(s) Per patient. Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Post Service Review	Four of (D9223, D9243) per 1 Day(s) Per patient. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20			Not allowed with D9243.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Post Service Review	One of (D9239) per 1 Day(s) Per patient. Requires Dentists to have anesthesia certification on file in their office for auditing purposes	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Post Service Review	Four of (D9223, D9243) per 1 Day(s) Per patient. Not allowed with D9223. This procedure code shall not be used for billing local anesthesia or nitrous oxide. Not allowed with D9230. Requires Dentists to have anesthesia certification on file in their office for auditing purposes	
D9248	non-intravenous moderate (conscious) sedation	0-9		Post Service Review	One of (D9248) per 1 Day(s) Per patient. Not allowed in conjunction with D9230 or D9243.	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

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

					Requires Dentists to have anesthesia certification on file in their office for auditing purposes	
D9248	non-intravenous moderate (conscious) sedation	10-20		Post Service Review	One of (D9248) per 1 Day(s) Per patient. No review required for ages 0-9. Pre-payment is required for ages 10-20.	narrative of medical necessity
D9410	house/extended care facility call	0-20		No	One of (D9410) per 1 Day(s) Per Provider OR Location.	
D9420	hospital or ambulatory surgical center call	0-20		No	One of (D9420) per 1 Day(s) Per Provider OR Location. No other procedures may be billed in conjunction with D9420. Not applicable for nursing home visits (D0150 or D9110). Can not bill conjunctively.	
D9944	Occlusal guard – hard appliance, full arch	0-20		Yes	One of (D9944, D9945, D9946) per 24 Month(s).	
D9945	Occlusal guard – soft appliance, full arch	0-20		Yes	One of (D9944, D9945, D9946) per 24 Month(s).	
D9946	Occlusal guard – hard appliance, partial arch	0-20		Yes	One of (D9944, D9945, D9946) per 24 Month(s).	
D9995	Teledentistry – synchronous; real-time encounter	0-20		No	Two of (D9995, D9996) per 6 Month(s).	
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	Two of (D9995, D9996) per 6 Month(s).	

Exhibit B Benefits Covered for Children's Medicaid and CHIP

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9986	Missed Appointment	0-20		No	One of (D9986, D9987) per 1 Day(s) Per patient. per record of broken or missed appointment. Not allowable in conjunction with any other benefit for the date of service filed. Documentation within patient record must support that a scheduled appointment was missed or broken.	
D9987	Cancelled Appoinment	0-20		No	One of (D9986, D9987) per 1 Day(s) Per patient. per record of broken or missed appointment. Not allowable in conjunction with any other benefit for the date of service filed. Documentation within patient record must support that a scheduled appointment was missed or broken.	
D9999	unspecified adjunctive procedure, by report	0-20		Yes		photos, xrays, treatment plan

ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF
MEMBER FINANCIAL RESPONSIBILITY

CONSENT FORM

Name of Member (the "Member") – *please print clearly*

Treating Provider (the "Provider") – *please print clearly*

Office/Location Name and Address

The Member or the Member's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program.

Accordingly, the undersigned agrees that the Member or Member's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

Code	DOS (if applicable)	Tooth/Surface/Arch	Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date: _____

Signature of Member or Member's Legal
Representative

Witness:



Continuation of Care Submission Form

Date: _____

Patient Information

Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information

Dentist Name:	Provider NPI #	Location ID#
Address:	City, State, Zip	Area code & Phone number:

Name of Previous Vendor that issued original approval: _____

Banding Date: _____

Case Rate Approved By Previous Vendor: _____

Amount Paid for Dates of Service That Occurred Prior to DentaQuest: _____

Amount Owed for Dates of Service That Occurred Prior to DentaQuest: _____

Balance Expected for Future Dates of Service: _____

Remaining services and quantities to be paid from prior approval:

Additional information required:

If approved through a prior Medicaid vendor, please submit the following:

- A complete Orthodontic Continuation of Care form
- A completed 2012 or greater ADA claim form listing the services to be rendered
- A copy of the member's prior approval letter including the total approved case fee and payment structure
- Detailed payment history
- A payment ledger
-

If approved through a private arrangement or commercial plan also include:

- A copy of the original study models or a complete set of diagnostic photographs prior to the patient being banded

Mail To:
DentaQuest - Attn: Continuation
PO Box 2906
Milwaukee, WI 53201-2906