DentaQuest®

DentaQuest USA Insurance Company, Inc.

Provider Manual

SUPERIOR HEALTHPLAN
STAR Health (Foster Care)

Statewide (effective 2/1/2024)

844-776-8740
www.dentaquest.com

This document contains proprietary and confidential information and may not be disclosed to others without written permission.
©Copyright 2022. All rights reserved.

superior healthplan™ Children's Medicaid | TEXAS Health and Human Services

Version 4.4

Feb 1, 2024

Current Dental Terminology © American Dental Association. All Rights Reserved

DentaQuest USA Insurance Company, Inc.
Address and Quick Reference Telephone Numbers

Provider Services
844.776.8740
DentaQuest Member Services:
888.308.4766

Superior Member Services (STAR Health):
866.912.6283

Superior Provider Services
Superior Provider Services (STAR Health):
866.439.2042

Superior Medical Management (Referrals/Authorizations):
800.218.7508

TTY Service
711

TMHP Contact Center/Automated Inquiry System (AIS)
800.925.9126 or 512.335.5986

Texas Access Alliance (STAR Help Line):
800.964.2777

Medical Transportation Program (STAR Health, STAR+PLUS):
877.633.8747

Authorizations should be sent to:
DentaQuest- Authorization PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.241.7150 or 888.313.2883

Credentialing applications should be sent to:
DentaQuest- Credentialing PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Claims should be sent to:
DentaQuest -Claims PO 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
PO Box 2906
Milwaukee, WI 53201-2906

Fax numbers:
Claims/payment issues: 262.241.7379 Claims to be processed: 262.834.3589 All other: 262.834.3450

Superior Medical Management Fax Number (Referrals/Authorizations):
800.690.7030

Claims Questions:
txclaims@dentaquest.com

Current Dental Terminology © American Dental Association. All Rights Reserved

Contents

Introduction 6
Program Background 6
Program Objectives 6
Dental Home Initiative 6
First Dental Home Initiative 6
Risk Caries Assessment 7
Resources 7
Covered Services 7
Texas Health Steps Dental Services 7
Exception to Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services for Texas Health Steps Dental Procedures 10
Health Passport (STAR Health) 11
Quality Improvement Program (Policies 200 Series) 13
Credentialing 14
The Patient Record 15
Patient Recall System Requirements 17
Utilization Management Program (Policies 500 series) 17
Provider Responsibilities 18
Health Insurance Portability and Accountability Act (HIPAA) 21
Second Opinion Reviews and Regional Screening 22
Medicaid Member Transportation (Non-Emergency) 22
Authorization for Treatment 23
Dental Treatment Requiring Authorization-Prior Authorization 23
Submitting Authorization or Claims with X-Rays 23
Electronic Attachments 24
Coordination of Non-Capitated Services 24
Coordination of Care – Outpatient Facilities and Hospitals 25
Provider Complaints and Appeals Process 25
Provider Complaints 25
Provider Claim Appeals 26
Member Complaint Process 21
Medicaid Member Complaint 21
What should I do if I have a complaint? 21
If the Member is not satisfied with the outcome, who else can they call? 21
MDCP/DBMD ESCALATION HELP LINE 21
What is the MDCP/DBMD Escalation Help Line? 21
When should I call the escalation help line? 22

Current Dental Terminology © American Dental Association. All Rights Reserved

Is the escalation help line the same as the HHS Office of the Ombudsman? 22
Who can call the help line? 22
Can I call any time? 22
Member Appeal Process 23
Pre-Appeal Process (STARHealth) 23
Medicaid Member Appeals 23
What can I do if DentaQuest denies or limits my member's request for a covered service? 23
How will I find out if services are denied? 24
Timeframes for the Appeal Process/Expedited Appeals 24
When does the member have the right to ask for an appeal? 24
Can someone from DentaQuest help me file an Appeal? 24
~~Expedited~~ Emergency Appeals 24
Who can help me file an ~~Expedited~~ Emergency Appeal? 24
STATE FAIR HEARING INFORMATION 24
Can I ask for a State Fair Hearing? 24
EXTERNAL MEDICAL REVIEW INFORMATION 25
Can a Member ask for an External Medical Review? 25
Can a Member ask for an emergency External Medical Review? 26
Program Eligibility 26
Member Identification Card 26
DentaQuest Eligibility Systems 26
Access to eligibility information via the Internet 27
Access to eligibility information via the IVR line 27
What is a Medical Consenter? 34
What is the role of a Medical Consenter? 34
CHILDREN'S MEDICAID DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITES MEMBER RIGHTS 34
STAR HEALTH MEMBER RIGHTS AND RESPONSIBILITES 35
25.00 Statement of Provider Rights and Responsibilities 36
26.00 FRAUD REPORTING 37
Claim Submission Procedures (claim filing options) 38
Electronic Claim Submission Utilizing DentaQuest's Internet Website 38
Electronic Authorization Submission Utilizing DentaQuest's Internet Website 38
Electronic Claim Submission via Clearinghouse 38
HIPAA Compliant 837D File 38
NPI Requirements for Submission of Electronic Claims 39
Paper Claim Submission 39
Coordination of Benefits (COB) 39

Current Dental Terminology © American Dental Association. All Rights Reserved

Member Billing Restrictions 40
Member Acknowledgement Statement 40
Private Pay Form (Non-Covered Services Disclosure Form) 40
Filing Limits 40
Receipt and Audit of Claims 40
Direct Deposit 41
Special Access Requirements 41
Interpreter/Translation Services 41
Reading/Grade Level Consideration 41
Cultural Sensitivity 42
Special Health Care Needs 43
Radiology Requirements 43
Radiographic Examination of the New Patient 43
Radiographic Examination of the Recall Patient 43
Clinical Criteria 45
Criteria for Dental Extractions 45
Criteria for Cast Crowns 46
Criteria for Endodontics 47
Criteria for Removable Prosthodontics (Full and Partial Dentures) 48
Criteria for the Excision of Bone Tissue 50
Criteria for the Determination of a Non-Restorable Tooth 50
Criteria for General Anesthesia and Intravenous (IV) Sedation 51
Criteria for Periodontal Treatment 54
Appendix A - 55
STAR HEALTH (FOSTER CARE) 55
Non-Covered Service Disclosure Form 59
OrthoCAD Submission Form 60
Continuation of Care Submission Form 61
Managed Care Orthodontia Review Policy and Procedure- Texas 64
RECALL EXAMINATION 71
Authorization for Dental Treatment 72
MEDICAL AND DENTAL HISTORY 73
APPENDIX F 76
Covered Benefits (See Exhibit) 76

Current Dental Terminology © American Dental Association. All Rights Reserved

Introduction

Program Background

DentaQuest USA Insurance Company, Inc. (DentaQuest) administers the STAR Health (Foster Care), STAR+PLUS, STAR and Superior HealthPlan Advantage programs for Superior HealthPlan. No other dental benefits administrator has the amount of experience, the level of clinical expertise, or the range of technology possessed by DentaQuest USA. We employ these tools to promote an efficient dental program that will give Medicaid and Medicare members of Texas the best chance to achieve a bright oral health future.

Within the STAR Health program, persons eligible to participate are children and young adults in Department of Family and Protective Services (DFPS) conservatorship, emancipated minors or Members age 18-22 who voluntarily agree to continue in a foster care placement, and young adults who have exited care and are participating in the Medicaid Transitional Foster Care Youth (MTFCY) Program ages 18-21. Former Foster Care in Higher Education (FFCHE) members who are at least 21 years of age, attending college or technical school within the state of Texas, may be eligible for STAR Health coverage through the month of their 23rd birthday.

STAR Health dental benefits are governed by Superior's Contract with HHSC. Superior's Dental Subcontractor must provide a dental benefit package to STAR Health Members that includes Fee-for-Service (FFS) services currently covered under the Medicaid program and complies with other requirements of Superior's contract with HHSC. Please refer to the current *Texas Medicaid Provider Procedures Manual* for listings of limitations and exclusions.

STAR+PLUS is a Texas Medicaid managed care program for eligible people who have physical or mental disabilities or who are elderly. Most adults on supplemental security income (SSI) will be required to enroll in STAR+PLUS if the program is offered in the area of the State where they live. SSI children may choose to enroll in STAR+PLUS or may remain in traditional Medicaid.

STAR (which stands for State of Texas Access Reform) is a Texas Medicaid managed care program for eligible individuals.

Superior HealthPlan Advantage is a Special Needs Plan for Medicare recipients and was created to help dual eligibles get the most out of the benefits and services available through Medicare and Medicaid. Members are provided access to personal, local care needed to help people stay healthy and independent.

Program Objectives

The primary objective of Superior HealthPlan and DentaQuest is to create a comprehensive dental care system for STAR Health members and a supplemental set of benefits for STAR+PLUS, STAR and Advantage members, by offering quality dental services to those eligible Texas residents. We emphasize early intervention and promote access to care, thereby improving health outcomes for Texas residents.

Dental Home Initiative

The "Dental Home" is the ongoing relationship between the dentist, who is the Primary Dental Care Provider, and the client, and includes comprehensive oral health care.
Establishment of a client's Dental Home begins no later than six (6) months of age. The Dental Home is a place where a child's oral health care is delivered in a complete, accessible, and family-centered manner by a licensed dentist. The concept of the Dental Home has been successfully employed by primary care physicians in developing a "Medical Home" for their patients, and the "Dental Home" concept mirrors the "MedicalHome" for primary dental and oral health care. Additionally, the establishment of the Dental Home assures appropriate referral to dental specialists when care cannot directlybe provided within the Dental Home. Provider support is essential to promote the DentalHome Initiative. With assistance and support from dental professionals, a system for improving the overall health of children in the Program can be achieved.

First Dental Home Initiative

Current Dental Terminology © American Dental Association. All Rights Reserved

Medicaid Members from six (6) through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every three
months if Medically Necessary. The First Dental Home visit can be initiated as early as six (6) months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment, and
- Dental anticipatory guidance.

Providers must be certified to be a Texas Health Steps Dentist. To become a First Dental Home Initiative Provider (THSteps), the dentist must complete either the online module or in-person training and submit registration information. The Texas Health Steps online First Dental Home Module is available at:

http://www.txhealthsteps.com/catalog/coursedetails.asp?crid=1772 or accessed through www.txhealthsteps.com.

Risk Caries Assessment

Effective for dates of service on or after October 1, 2015, benefit criteria for diagnostic dental services have changed for Texas Medicaid.

A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same date of service when dental examination procedure codes D0120, D0145, or D0150 are submitted for reimbursement.

The member's dental condition(s) that justifies the risk assessment classification submitted with the claim must be maintained by the provider in the member's medical record, and it must be clearly documented using a caries risk assessment tool or in narrative charting. The member's medical record is subject to retrospective review.

Procedure codes D0601, D0602, and D0603 are informational only, and are payable at
$0.

Note: Beginning January 1, 2016, procedure codes D0120, D0145, and D0150 will be denied if procedure code D0601, D0602, or D0603 is not submitted on the same date of service.

Resources

The following professionally-developed caries risk assessment tools are available on the American Dental Association (ADA), American Academy of Pediatric Dentistry (AAPD), and Department of State Health Services (DSHS) Oral Health Program websites:

- www.ada.org/~/media/ADA/Member%20Center/FIles/topics_caries_instructions.ashx
- www.ada.org/~/media/ADA/Member%20Center/FIles/topics_caries_under6.ashx
- www.ada.org/~/media/ADA/Science%20and%20Research/Files/topic_caries_over6.ashx
- www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf www.dshs.state.tx.us/dental/Caries-Risk-Assessment.shtm

Covered Services

Texas Health Steps Dental Services

THSteps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). THSteps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients who are from birth through 20 years of age. THSteps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national

Current Dental Terminology © American Dental Association. All Rights Reserved

and state dental professional organizations. THSteps' designated staff (Texas Department of State Health Services [DSHS], Department of Assistive and Disability Services [DADS], or contractor), through outreach and informing, encourage eligible children to use THSteps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

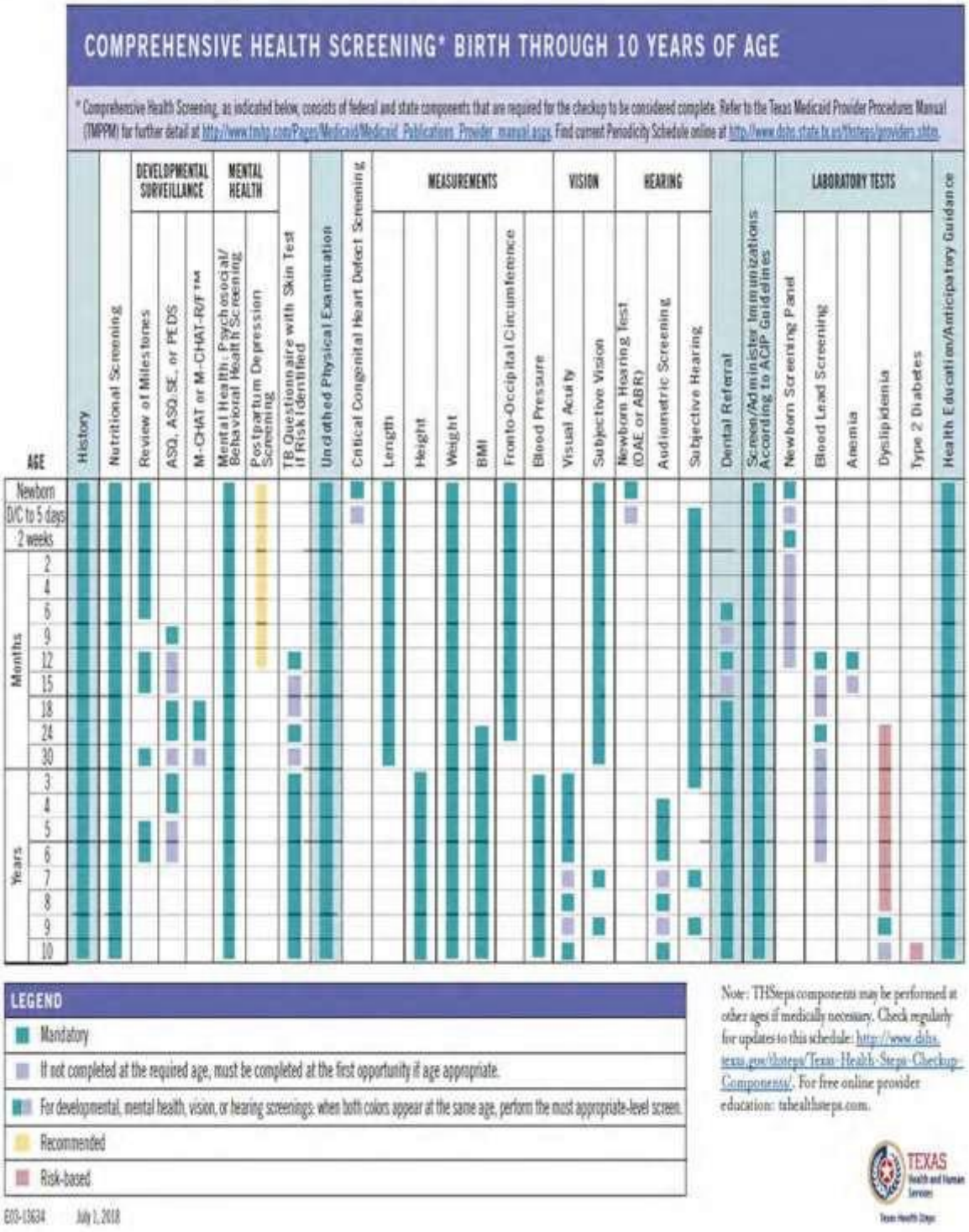
STAR Health members have access to the benefits in addition to the traditional Medicaid member with the following additions and requirements for appointment times for Texas Health Steps. STAR Health Members must have a Dental exam within 60 days of enrollment for members 6 months of age and older, and every 6 months thereafter through the month of their 21st birthday.

The MCO must arrange for timely THSteps dental checkups for all eligible Members, except when the Member, Member's Caregiver, or Medical Consenter knowingly and voluntarily declines or refuses THSteps services after receiving sufficient information to make an informed decision. The MCO must notify the DFPS caseworker of all refusals to obtain a THSteps checkup for the Member.

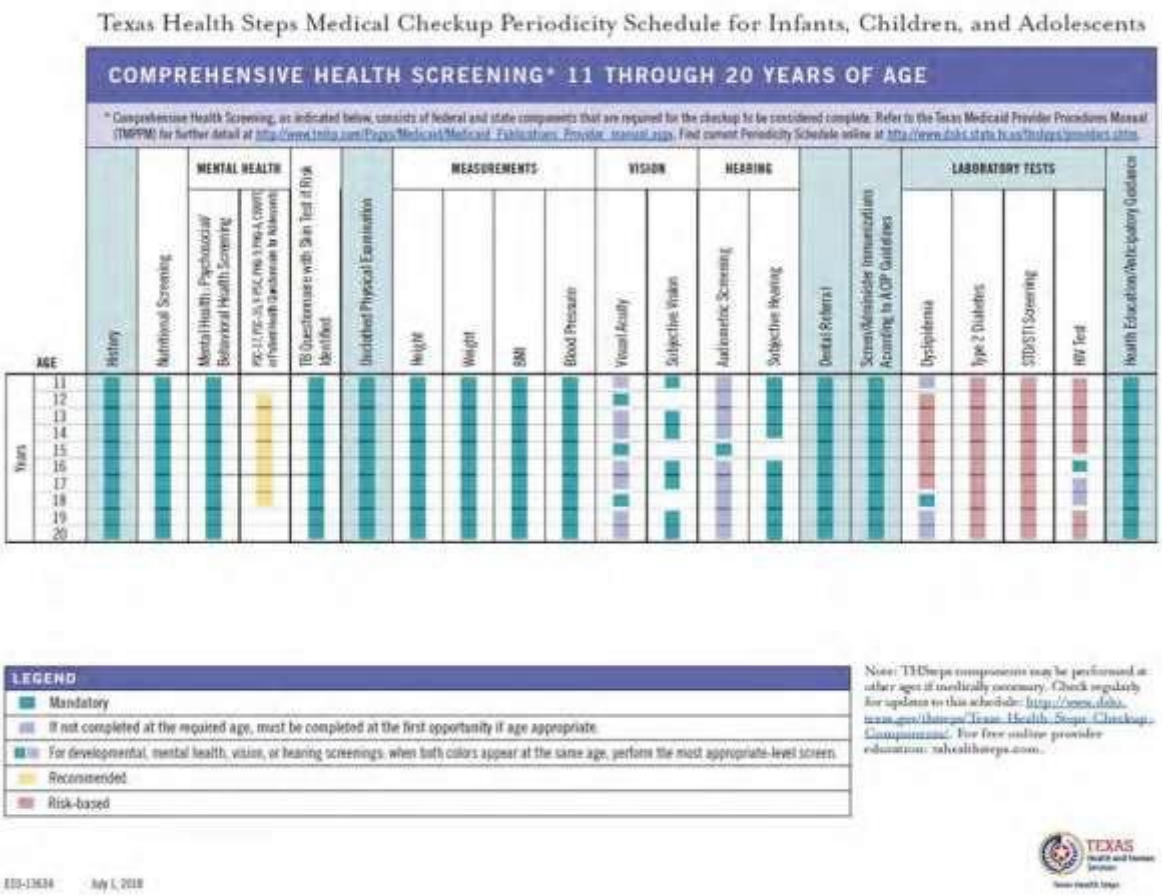
For more information about Texas Health Steps, refer to the *Texas Medicaid Provider Procedures Manual*.

Current Dental Terminology © American Dental Association. All Rights Reserved

Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents



Current Dental Terminology © American Dental Association. All Rights Reserved



Exception to Periodicity Oral Evaluation, Dental Checkup, and Emergency or Trauma Related Services for Texas Health Steps Dental Procedures

Oral evaluations and dental checkups allow for the early diagnosis and treatment of dental problems. They might be needed at more frequent intervals than noted in the periodicity schedule. If needed, a dental checkup or oral evaluation can still be reimbursed when the service falls outside the periodicity schedule. The rules for such exceptions are outlined below.

Exception-to-Periodicity Oral Evaluation

A Texas Health Steps exception-to-periodicity oral evaluation is limited to dental procedure code D0120.
An exception-to-periodicity oral evaluation is allowed when the service is:

- Medically necessary and based on risk factors and health needs for members birth through 6 months of age.
- Mandated service required to meet federal or state exam requirements for Head Start, daycare, foster care or preadoption.

Providers must include all appropriate procedure codes on the dental claim submission form. Providers would need to include a narrative and comment in box 35.

Exception-to-Periodicity Dental Checkup

A Texas Health Steps exception-to-periodicity dental checkup is allowed when:

- The member will not be available for the next periodically due dental checkup.

Providers must include all appropriate procedure codes on the dental claim submission form.

Exception-to-Periodicity Emergency or Trauma Related Oral Evaluation

A Texas Health Steps exception-to-periodicity emergency or trauma related oral evaluation is limited to dental procedure code

Current Dental Terminology © American Dental Association. All Rights Reserved

D0140. Procedure code D0140 is limited to once per day for the same provider and twice per day for any provider.

A Texas Health Steps exception-to-periodicity emergency or trauma related dental service will be allowed when the service is:

- Required for immediate treatment and any follow-up treatment.
- Required for therapeutic services needed to complete a case for members, 5 months of age and younger, when initiated as emergency services, trauma, or early childhood caries.

When submitting a claim for emergency or trauma related dental services, the provider must include:

- "Trauma" or "Emergency" in Block 35, "Remark" field
- The original date of treatment or incident in Block 35, "Remark" field

Providers must include all appropriate procedure codes on the dental claim submission form.

Adjunctive General Services

When submitting a claim for an unclassified treatment procedure code D9110 the provider must include:

- "Trauma" or "Emergency" in Block 35, "Remark" field
- The original date of treatment or incident in Block 35, "Remark" field

Providers must include all appropriate procedure codes on the dental claim submission form.

Health Passport (STAR Health)

The Health Passport is a patient-centered, internet-based health record. It makes a foster child's information available to authorized providers and medical stakeholders, such as medical consenters and caseworkers. The data in the Health Passport is not a person's complete medical record, but it does contain information on patient demographics, doctor visits for which claims have been paid or denied, allergies, lab test results, immunizations, and filled medications. There are also electronic Texas Health Steps, Dental, and Behavioral Health forms available through the Health Passport. The Member's Dentist must timely submit all required information for the Health Passport.

What is the advantage of using the Health Passport?

The Health Passport allows providers and medical stakeholders to view more patient information than has been available to them in the past. With this new information, providers have the opportunity to cut down on errors due to missing information and to reduce costs by eliminating duplicative tests, immunizations, and prescriptions. More specifically, providers can see more information about patients they thought they knew very well and they can see more info about new patients who they have never seen before. In addition to these benefits, the Health Passport is free.

Health Passport Questions and Answers

How does the Health Passport differ from the Electronic Medical Record (EMR) or Electronic Health Record (EHR)?

There are several major differences between the Health Passport and the EMR or EHR. The first is that the EMR is a patient's COMPLETE medical record. The Health Passport does not contain all the information that the EMR does.

Second, the EMR only contains comprehensive information from one healthcare provider or health care system. The Health Passport contains select information from many providers and facilities. The EMR must be maintained and updated by the providers who use it, but the Health Passport is maintained and updated by the STAR Health program. Most of the information in Health Passport can be viewed by a provider but cannot be changed. There are only a few areas that are interactive- Vital Signs, Allergies, and the Texas Health Steps, Dental, and Behavioral Health forms – where providers can add information into the Health Passport.

Whose information is included in the Health Passport?

Each foster child's demographic information, and paid and denied medical, behavioral, pharmacy, dental, and vision claims. Other information includes lab results, as well as each foster child's immunization history.

You say the Health Passport is free, but what is the real cost for providers?

In order to use the Health Passport, providers must have access to a computer with internet connectivity. There is also a small-time investment initially in learning how to use it, but in the long run, the Health Passport should save providers time and money

Current Dental Terminology © American Dental Association. All Rights Reserved

when trying to locate information on patients.

For providers who do not have access to the internet, they are able to acquire Health Passport information from Superior Service and Care coordinators.

How often is the information in the Health Passport updated?

Demographics and contact information – Daily
Medical & Behavioral Health claims – Daily
Pharmacy claims – Daily
Dental & Vision claims – Bi-weekly
Quest Labs data – Weekly
Immunizations (ImmTrac, State Registry) – Monthly

Is the data in the Health Passport driven by codes?

Some of the data in the Health Passport is claims information, and in the Claim Details information (Visits Module), the viewer can see specific CPT codes (procedure codes), HCPCS codes and J codes; however, the codes are also described using words to make viewing easy and beneficial for both clinical and non-clinical users.

How do you verify that the information being uploaded in the Health Passport is being placed on the correct person's chart? Example: Two people with the same name or names that sound very similar.

A Master Person Index is used to match Members in the Health Passport. Members are matched to their records by their names as well as several other factors, such as date of birth and unique numeric identifiers.

Is the claims data based on both paid and denied claims?

Yes, the Health Passport will show claims that are on file. This means that it will show claims that have been paid or that have been denied. Medication claims are the exception. The Health Passport does not show denied medication claims, because the pharmacy ensures that the prescription will be paid by the insurance before the prescription is filled.

Will pending claims show up on the Health Passport?

No. The claim will not show up on the Health Passport until after it has been processed by the payer.

What is the source of patient demographic information?

The foster child's demographic information will be updated daily by the Texas Department of Family Protective Services (DFPS).

If there are no allergies recorded for a patient, does it mean that they do not have any allergies?

No. The Health Passport allergy section is an interactive section that depends on provider input for updating. If "No allergy information has been documented for this person" is displaying in the Allergies section, the patient may have allergies, but no provider has documented them in the Health Passport yet. If "No Known Allergies" is displaying in the Allergies section, it means that a provider has documented that the patient has no allergies to their knowledge. We strongly encourage providers to take just a minute to add in any allergies they are aware of.

If a provider adds information to a patient's chart, is the information available to all providers immediately?

Yes. The Allergies, Vital Signs, and Forms sections are interactive sections, and information input into any of these sections is updated immediately to the member's Health Passport record.

Is the Fill Date in the Medications Claims section the date the prescription was written or the date the medication was dispensed?

The medication fill date is the date that the medication was dispensed.

Current Dental Terminology © American Dental Association. All Rights Reserved

How can the system help patients who have potential drug interactions?

The Medications section of the Health Passport will be helpful in preventing possible drug interactions. If providers are able to see what medications the patient is already taking, he or she can avoid prescribing drugs that could cause an interaction. This could be especially helpful in Emergency Departments where providers frequently do not have all the information they need before giving treatment to the patient.
The Health Passport also contains an Allergies section. The patient's providers enter the allergies and having this information is helpful to providers as they prescribe medications. When the patient has an allergy to a medication, an allergy icon will appear next to that prescription. The allergy icon is a red A with a box around it.

What does the Lab Results date and time mean?

The date and time are when the lab processes the test.

What are the requirements for a user to be able to use the Health Passport?

A user needs a computer, preferably a high-speed internet connection, and authorization (username and password) to access the Health Passport. Authorization is granted to participating providers. To gain authorization, simply go to www.superiorhealthplan.com(for physical health providers) or www.cenpatico.com (for behavioral health providers) and register to use the Health Passport via the secure provider portal.

What if a user has dial-up internet, instead of high speed?

The Health Passport will work with dial-up internet, but it will be slower.

What is considered a "high speed connection"?

High speed internet access is a connection that is faster than dial-up– approximately 100 mbps (megabits per second) or faster.

What are the recommended hardware requirements?

Recommended requirements for the PC are:

- 512MB RAM
- 512MB disk
- 1Ghz CPU
- Internet Explorer 6.0 or higher (free to download)
- FireFox 2.0 or higher (free to download)
- Adobe Acrobat 6.0.2 or greater (a free download at www.adobe.com)
- Java 1.05 or greater (a free download)
- 1024 x 768 screen resolution

How fast is the system?

This depends on many factors:

- Type of hardware (ex. computer) and internet connection being used
- Size of the patient's chart
- How many other users are currently using the system
- Version of Internet Explorer

The network the provider may be using could have some impact (ex. How many firewalls the provider must go through on their network).

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

Current Dental Terminology © American Dental Association. All Rights Reserved

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 Review
- 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 Customer Service department at 844.776.8740 or via e-mail at: denelig.benefits@dentaquest.com

Credentialing

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and program requirements. DentaQuest, in conjunction with the program, has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of DentaQuest's credentialing policies and procedures is to provide a general guide for the acceptance, discipline, and termination of Participating Providers. DentaQuest reviews each Participating Provider's practice history including, but not limited to, license actions, quality of care issues, and any history of criminal conduct, when making credentialing decisions.

Nothing in this Office Reference Manual or DentaQuest's credentialing policies and procedures limits DentaQuest's sole discretion to accept and discipline Participating Providers, including the right to restrict or suspend a Participating Provider's network participation.

Credentials Committee Denials (Policy PEC01)

If a provider's application to be a Participating Provider has been denied by DentaQuest's Credentials Committee, the provider must wait twelve (12) months from the date of his or her denial letter to reapply for participation in the network.

Recredentialing (Policy PEC01)

All actively participating providers must be reviewed every thirty-six (36) months from the date of their previous credentialing actions.

Disciplinary Actions, Corrective Action Plans & Provider Appeals (Policy PEC05)

This policy includes actions which may be taken by DentaQuest in the event of quality of care issues, noncompliance with program requirements, or failure to adhere to DentaQuest's policies and procedures by Participating Providers.

Appeal of Credentials Committee Termination (Policy PEC05)

If the Credentials Committee terminates a Participating Provider from network participation, the Committee will offer the provider an opportunity to appeal the termination. The provider must request an appeal in writing and the request must be received by DentaQuest within thirty (30) days of the date the Committee gave notice of its decision to the provider. If the Credentials Committee decides to uphold a Participating Provider's termination on appeal, the Participating Provider must wait twelve (12) months from the date of his or her decision letter to reapply for participation in the network.

Note: The aforementioned policies are available upon request by emailing credentialscommittee@greatdentalplans.com

Current Dental Terminology © American Dental Association. All Rights Reserved

The Patient Record

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.

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.

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

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

Current Dental Terminology © American Dental Association. All Rights Reserved

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. Indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

10. Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

11. 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.

Current Dental Terminology © American Dental Association. All Rights Reserved

e. Patient receptiveness/compliance.
f. Recall interval.
g. Date.

12. Adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

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

14. Adequate documentation of the specialty care performed by another dentist that includes:
    a. Patient examination.
    b. Treatment plan.
    c. Treatment status

Patient Recall System Requirements

Recall System Requirement
Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments and missed appointments for any health plan 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 check-ups are needed to keep your teeth healthy."

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

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

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

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

Utilization Management Program (Policies 500 series)

Introduction

Current Dental Terminology © American Dental Association. All Rights Reserved

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.

Community Practice Patterns

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

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.

Results

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

Provider Responsibilities

Office Compliance Verification Procedures

In conjunction with its office claim audits described, 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. Dental appointments are to be made during normal business hours and within a reasonable time from the date of the member's request. Appointment Standards are:

- Routine- 30 calendar days
- Therapeutic/diagnostic- 14 calendar days
- Urgent- 24 hours

Current Dental Terminology © American Dental Association. All Rights Reserved

Emergency dental services are limited to the following:

- Procedures necessary to control bleeding, relieve pain, and eliminate acute infection
- Operative procedures required to prevent imminent loss of teeth; and
- Treatment of injuries to the teeth and supporting structures

Routine restorative procedures and root canal therapy are not emergency services. Emergency services must be justified with documentation. The dentist's narrative documentation should describe the nature of the emergency, including relevant clinical information about the patient's condition and stating why the emergency services rendered were considered to be immediately necessary.

Routine dental services include diagnostic and preventive visits. Therapeutic services are those such as fillings, crowns, root canals and/or extractions.

Emergency Dental Services

DentaQuest is not responsible for coverage or payment of Non-Capitated Services, including emergency dental services provided to Members in a hospital or ambulatory surgical center setting. DentaQuest will educate Members and Providers about the availability of, and how to access, Non-Capitated emergency dental services. DentaQuest must refer Members to Non-Capitated Service providers and provide coordination of care for Non-Capitated Services. This coordination of care must include:

- identifying providers of Medically Necessary dental services; and
- helping the Member access needed Medically Necessary dental services to the extent they are available to the member.

DentaQuest is responsible for informing Providers that bill for all Non-Capitated Services must be submitted to Superior HealthPlan or HHSC's Claims Administrator, as appropriate.

EMERGENCY Treatments and Authorizations

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

Please FAX this to 262-241-7150.

DentaQuest will process emergency authorization requests as high priority.

After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

Standard of Care

All covered dental services shall be provided according to generally accepted standards of dentistry prevailing in the professional community at the time of treatment. Contracting dentists are required to integrate specialty care into the Member's course of dental treatment by making timely referrals to a specialist when necessary or appropriate. Specialty providers are responsible for providing the appropriate care to Members who have been referred. Contracting dentists may not impose any limitations on the acceptance or treatment of Superior Members not imposed on other patients. The dentist is required to maintain the dentist/patient relationship with the Superior Member and shall be solely responsible to the Member for dental advice and treatment.

Provider Preventable Conditions

Provider-preventable condition" has the same meaning as "provider-preventable condition" provided in 42 C.F.R. 447.26 and

Current Dental Terminology © American Dental Association. All Rights Reserved

includes the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. For purposes of this term, most dental procedures, other than preventative procedures, will be considered “invasive”.

DentaQuest must not pay for Provider-preventable conditions. DentaQuest must ensure its Provider Contracts contain language requiring Providers to report to DentaQuest the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. DentaQuest must also submit quarterly reports of Provider-preventable conditions to the HHSC health plan monitoring team and the HHSC Dental Director.

Professional Conduct

While performing the services described in the Network Provider contract, the network Provider agrees to:

- Comply with applicable state laws, rules, and regulations and HHSC’s requests regarding personal and professional conduct generally applicable to the service locations; and
- Otherwise conduct themselves in a businesslike and professional manner.

Provision of Services

Provider shall render to Members all Covered Services and continue to provide Covered Services to Members. After the date of termination from participation, upon the request of DentaQuest, Provider shall continue to provide Covered Services to Members for a period not to exceed ninety (90) days during which time payment will be made pursuant to the DentaQuest Provider Contract.

Please refer to the DentaQuest TX Provider Contract for more information regarding termination.

Provider Directory

DentaQuest publishes a provider directory to Members. The directory is updated periodically and includes: provider name, practice name (if applicable), office addresses(s), telephone number(s), provider specialty, panel status (for example, providers limiting their practice to existing patients only), office hours, and any other panel limitations that Superior is aware of, such as patient age minimum and maximum, etc.

It is very important that you notify DentaQuest of any change in your practice information. Please complete the Provider Change Form, fax it to DentaQuest at 262.241.4077 or call us at 844.776.8740 to report any changes.

Broken Appointments – Best Practices

Broken appointments are a concern for Superior and DentaQuest. We recognize that broken appointments are a costly and unnecessary expense for providers. Our goal is to remove any barriers that prevent dentists from participating in the program as well as barriers that prevent our Members from utilizing their benefits.

As a result of feedback we have received from dentists in the community, we have developed several Broken Appointment Best Practice guidelines. We encourage you to implement these practices in your office.

The following list contains office policies which have helped to reduce broken appointments and the effects of broken appointments in other dental practices.

- Confirm appointments after hours when the patient is likely to be home to answer the call.
- Confirm all appointments, including recall and hygiene appointments, the day before the appointment.
- Consider telling patients they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- Continuing care appointments made for three to six months ahead should be reserved for patients of record with no history of broken appointments.
- Patients with a history of broken appointments or that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency patients will not keep future appointments if scheduled on the day of emergency treatment. These patients should be called later during the week to schedule follow-up treatment.

Current Dental Terminology © American Dental Association. All Rights Reserved

- When a procedure needs to be completed at a subsequent appointment, send information home with patients about that next appointment. The information should stress the importance of such a procedure and indicate possible outcomes if it is not completed within the designated timeframe.
- Maintain a list of patients that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many patients cite daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of the week or occasional weekend hours can alleviate this barrier to accessing dental care.

Logging Broken Appointments in the Provider Web Portal

Entering a Member's broken appointment is an easy alternative to faxing broken appointment information to DentaQuest. By using the Broken Appointment tool, providers and office staff can enter the date and reason for the broken appointments or view a list of missed appointments.

The Broken Appointment page is comprised of 2 sections:

- Add Broken Appointment
  - This is where you add a member's broken (missed) appointment.
- Broken Appointment History
  - In this section, you can view a list of all missed appointments of a specific member.

Referrals to Specialists

Superior HealthPlan Members do not require authorization to see a dental specialist. However, only services provided by a Contracting Dentist are covered by DentaQuest, therefore a Superior HealthPlan Member must be treated by a dentist enrolled in DentaQuest. In the event it is necessary to refer a Member to a specialist for treatment, please be sure to refer the Member to a contracted DentaQuest dentist. You may look at the DentaQuest website to locate a dental specialist in the area.

Members with Special Health Care Needs may have direct access to Specialists as appropriate for the Member's condition and identified needs.

If you cannot locate a specialist in your area, you may call DentaQuest's Provider Call Center's toll-free telephone number at 844.776.8740 to facilitate a Member referral to a Specialist.

Continuity of Care

Subject to compliance with applicable federal and state laws and professional standards regarding the confidentiality of dental records, participating dentists must assist DentaQuest in achieving continuity of care for Superior Members through the maximum sharing of Members' dental records. Within 30 days of a written request by a Member, you must be able to provide copies of the patient's dental records to any other dentist treating such Member. This also applies when a Member moves out of the area. Superior HealthPlan Members are not subject to limitations or exclusions of covered dental benefits due to a pre-existing condition.

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 to ensure that it is compliant with the Privacy Standards as well. DentaQuest also intends to comply with all Administrative Simplification and Security Standards by their compliance dates. One aspect of our compliance plan will be working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has/will be modifying its provider contracts to reflect the appropriate HIPAA compliance language. The contractual updates include the following in regard to record handling and HIPAA requirements:

Current Dental Terminology © American Dental Association. All Rights Reserved

- 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 manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT 2009-2010 codes listed in this manual. In addition, all paper claims must be submitted on a 2018, 2019, or later approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 844.776.8740 or via e-mail at denelig.benefits@dentaquest.com.

Second Opinion Reviews and Regional Screening

DentaQuest may request a clinical evaluation by a regional dental consultant who conducts clinical examinations, prepares objective reports of dental conditions and evaluates treatment that is proposed or has been provided for the purpose of providing DentaQuest with a second opinion.

A second opinion may be required prior to treatment when necessary to make a benefit determination. Authorization for second opinions after treatment can be made if a Member has a complaint regarding the quality of care provided. The Member and the treating dentist will be notified when a second opinion is necessary and appropriate. When a second opinion is authorized through a regional dental consultant, all charges will be paid by DentaQuest.

Members may otherwise obtain a second opinion about treatment from any contracting dentist they choose, and claims for the examination or consultation may be submitted for payment. Such claims will be paid in accordance with the benefits of the program.

Out of Network (OON) Referrals

Out of network referrals are covered only if:

- The service is medically necessary and the covered service is not available through an in-network provider.
- The existing (in-network) provider requests that the work be done by an OON provider (referral).
- Reimbursement for Medicaid OON providers is 95% of the fee-for-service rate in effect on the date-of-service unless a different reimbursement amount is agreed upon.

Please contact Provider Services for assistance in locating an in-network provider.

Medicaid Member Transportation (Non-Emergency)

HHSC's Medical Transportation Program (MTP) is designed to serve Medicaid Members that have no other means of transportation for medical, behavioral, dental or vision appointments. MTP will utilize the most cost-effective method of

Current Dental Terminology © American Dental Association. All Rights Reserved

transportation that does not endanger a patient's health.

A Member should contact the Texas Department of Health Medical Transportation Program (MTP) at 1-877-633-8747 (toll-free) to learn more or set up a ride. Members should call as soon as they know their next appointment date. MTP requires at least 48 hours notice for most requests. The Member should notify MTP if they have any type of special needs so MTP can send the right type of vehicle. For example, for people who use a wheelchair, MTP can send a van with a wheelchair ramp.

Members under the age of 18 may be required to travel with an adult. Transportation specialists are available to take requests weekdays 8:00 a.m. to 5:00 p.m. You can go to www.HHSC.state.tx.us and click on "Questions about your benefits?"

The MTP program may also reimburse mileage for the Member, a Caregiver/Medical consenter, friend or someone else to take the client to health care services; if the trip is scheduled in advance and the driver abides by the MTP guidelines.

Authorization for Treatment

Dental Treatment Requiring Authorization-Prior Authorization

Authorizations are utilization tools that require Participating Providers to submit "documentation" associated with certain dental services for a Member. Participating Providers will not be paid if this "documentation" is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, and Superior harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to submit documentation for review after the service is rendered. Authorization can be made through prior approval or by prepayment review. Prior authorization is optional for all covered procedures with the exception of all Orthodontic codes (see Requirements identified in Exhibit A).

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. Please review these criteria as well as the benefits covered (Exhibits) to understand the decision making process used to determine payment for services rendered.

Prior Authorization- Dental services or treatment locations that require review by DentaQuest for determination of medical necessity and approval before delivery are subject to prior authorization. Proper documentation must be submitted with requests for prior authorization. Approved authorizations expire after 180 days and Orthodontic authorizations expire after 3 years.

Your submission of "documentation" should include:

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

Your submission should be sent on a 2018, 2019, or later ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked "Authorization Required." A "Yes" in this column indicates that the service listed requires prior-authorization. The "Documentation Required" column will describe what information is necessary for review. 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.

Submitting Authorization or Claims with X-Rays

- 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.

Current Dental Terminology © American Dental Association. All Rights Reserved

Please note we also require radiographs be mounted when there are 4 or more radiographs submitted at one time. If 4 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 2018, 2019, 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.

It is important not to submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. **DentaQuest does not generally return x- rays and other supporting documentation. However, if you wish to have your x- rays returned, they must be submitted with a self-addressed stamped envelope.**

Electronic Attachments

A. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests and claims submissions. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Enrolled Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.
FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouses or practice management systems.
For more information or to sign up for **FastAttach** go to www.nea-fast.com or call NEA at 800.782.5150.

B. **OrthoCAD™** DentaQuest accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. Submissions using **OrthoCAD™** also require the submission of the form found on page A-4. DentaQuest allows Enrolled Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. **OrthoCAD™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged models 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 **OrthoCAD™** go to www.orthocad.com or call **OrthoCAD™** at 800.577.8767.

Coordination of Non-Capitated Services

Medicaid Services Not Covered by DentaQuest

The following Texas Medicaid programs and services are paid for by HHSC's claims administrator instead of DentaQuest. Medicaid Members can get these services from Texas Medicaid providers.

1. Early Childhood Intervention (ECI) case management/service coordination;
2. DSHS case management for Children and Pregnant Women;
3. Texas School Health and Related Services (SHARS);
4. Health and Human Services Commission's Medical Transportation.

Current Dental Terminology © American Dental Association. All Rights Reserved

Either the member's medical plan or HHSC's claims administrator will pay for devices for craniofacial anomalies, and for emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (E.G., anesthesia and drugs for:

1. Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
2. Treatment of oral abscess of tooth or gum origin; and
3. Treatment craniofacial anomalies.

If a member is in need of assistance in coordinating any non-capitated services, a Member Advocate may be contacted to assist. Please contact our Member or Provider Service Line and ask to be referred to a Member Advocate.

Coordination of Care – Outpatient Facilities and Hospitals

DentaQuest does not require Participating Providers to prior authorize dental services performed under general anesthesia. Should the Participating Provider want or need assistance in coordinating care with Superior, the Provider may contact DentaQuest Provider Services and request assistance from a Member Advocate. The Member Advocate will collect the prior authorization request with date and place of service indicated. DentaQuest will review the case for medical necessity, and render an approval or denial of the planned treatment. Once DentaQuest has approved the case, a DentaQuest Member Advocate will coordinate authorization for non-dental services with Superior, as appropriate.

Coordination of all specialty care is the responsibility of the member's primary care provider. The primary care provider must be notified by the dentist or the MCO of the planned services. Dentists providing sedation or anesthesia services must have the appropriate current permit from the TSBDE for the level of sedation or anesthesia provided.

Provider Complaints and Appeals Process

Provider Complaints

Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. If a complaint cannot be resolved within 30 days, the provider will be notified in writing the status of the complaint.

Complaints to DentaQuest may be submitted using the following methods:

(non-claim related) • By telephone at 844.776.8740

(Claim related) • In writing to:

DentaQuest- TX Superior Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

If a provider is not satisfied after completing the DentaQuest Complaint Process or feels that they did not receive due process, providers may file a complaint with HHSC. A provider must exhaust the DentaQuest Complaint Process before filing with HHSC.

Medicaid complaint requests may be mailed to the following address:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code 91X

Current Dental Terminology © American Dental Association. All Rights Reserved

PO Box 204077
Austin, TX 78720-4077

Or e-mail complaint requests to:
HPM_Complaints@hhsc.state.tx.us

Provider Claim Appeals

For appealed claims, Providers must submit all appeals of denied claims and requests for adjustments on paid claims within **one hundred and twenty (120) days** from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared. If you have questions regarding claims, please contact DentaQuest Provider Services at844.776.8740.

Current Dental Terminology © American Dental Association. All Rights Reserved

Member Complaint Process

Medicaid Member Complaint

A Medicaid complaint is an expression of dissatisfaction expressed by a member, orally or in writing to DentaQuest, about any matter other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

What should I do if I have a complaint?

We want to help. As a Member, you have the right to file Complaints to DentaQuest and HHSC. If you have a complaint, please call us toll-free at 888.308.4766 to tell us about your problem. Complaints must be submitted within 30 days from date of incident or event. A DentaQuest Member Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days. You can also send your complaint in writing to:

DentaQuest- TX Superior Dental Services
Complaints & Grievance
Stratum Executive Center
11044 Research Blvd Building D, Suite D-400
Austin, TX 78759

Once we receive your complaint, DentaQuest will acknowledge your complaint within 5 business days of receipt. We will respond within 30 calendar days of receipt of your complaint.

The resolution letter will:

1. Explain the resolution of the complaint.
2. State the specific dental and contractual reasons for the resolution.
3. State the specialization of any dentist or other Provider consulted; and
4. Include a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

If the Member is not satisfied with the outcome, who else can they call?

Once you have gone through the DentaQuest complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission Health Plan
Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to:

HPM_Complaints@hhsc.state.tx.us

MDCP/DBMD ESCALATION HELP LINE

What is the MDCP/DBMD Escalation Help Line?

The MDMDCP/DBMD Escalation Help Line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf Blind with Multiple Disabilities (DBMD) program.
The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about Medicaid fair hearings and continuing services while appealing.

Current Dental Terminology © American Dental Association. All Rights Reserved

When should I call the escalation help line?
Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?
No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?
You, your authorized representative or your legal representative can call.

Can I call any time?
The escalation line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

¿Qué es la línea de escalamiento del MDCP/DBMD?

La línea de escalamiento del MDCP/DBMD ayuda a las personas con Medicaid que reciben beneficios del Programa para Niños Médicamente Dependientes (MDCP) o del Programa para Personas Sordociegas con Discapacidades Múltiples (DBMD).

La línea de escalamiento le ayuda a resolver problemas relacionados con el programa de atención médica administrada STAR Kids. Esa ayuda puede consistir en darle respuesta a las dudas que pueda tener sobre las audiencias imparciales de Medicaid o sobre la continuación de los servicios mientras se lleva a cabo la apelación.

¿Cuándo puedo llamar a la línea de escalamiento?
Llámenos si ha tratado de obtener ayuda y no ha recibido el tipo de ayuda que necesitaba. Si no sabe a quién recurrir, puede llamarnos al 844-999-9543 y nosotros nos encargaremos de ponerlo en contacto con el personal adecuado.

¿Es esta la misma oficina que la Oficina del Ombudsman de HHS?
No. La línea de escalamiento del MDCP/DBMD forma parte del programa Medicaid. El Ombudsman le ofrece una revisión independiente de sus inquietudes. Para obtener ayuda del Ombudsman comuníquese al 866-566-8989, o visite el sitio de internet hhs.texas.gov/managed-care-help. La línea de escalamiento del MDCP/DBMD está dirigida a individuos y familias que reciben beneficios del programa MDCP o DBMD.

¿Quiénes pueden llamar a la línea de ayuda?
Usted, su representante autorizado o su representante legal.

¿Puedo llamar a cualquier hora?
La línea de escalamiento está disponible de lunes a viernes de 8:00 a.m. a 8:00 p.m. Si llama después de este horario, deje un mensaje y uno de nuestros empleados de guardia capacitado se comunicará con usted.

Effective January 1, 2019 - Retro eligibility Recoupment Process

Funds will be recouped from paid claims with dates of service on or after January 1, 2019 where the member's eligibility has been retro-actively terminated. All decisions with regards to payment are subject to appeal. You may appeal our handling of payment by submitting a written request for review to HHSC.

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment

Current Dental Terminology © American Dental Association. All Rights Reserved

EOB.

- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission HHSC
Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Member Appeal Process

Pre-Appeal Process (STARHealth)

The Pre-Appeal Process takes place when upon the review of an authorization request for Member services, DentaQuest concludes there is either a) insufficient clinical or other information for a Covered Service to be authorized, or b) the available information does not meet the Medical Necessity criteria for the Covered Service. In this case, DentaQuest staff will contact the requesting Provider's office to determine if additional information is available. If additional information is available and, upon review of such information, DentaQuest determines that the Covered Service meets Medical Necessity criteria, it will approve the Covered Service within three (3) Business Days of receipt of the service authorization request. If additional information is not available, the request for services is transferred to the Dental Director, or his/her designee, for review.

The Dental Director, or his/her designee, will make at least two (2) attempts to schedule a peer- to peer review to obtain additional clinical information and/or coordinate to provide acceptable alternative care options. The second attempt to contact the provider will be made no sooner than four (4) business hours after the first attempt. The Dental Director, or his/her designee, will consider any new information presented. In cases where all information relevant to the decision is available and the Covered Service meets Medical Necessity criteria, the requested services will be approved within fifteen (15) days from the date the additional information was requested. If, after all new information is reviewed, the Covered Service still does not meet Medical Necessity criteria, the DentaQuest staff will request to obtain all available and necessary information relevant to the Pre-Appeal, by contacting the FFCHE Member, or the non-FFCHE Member's Medical Consenter, Caregiver, and/or DFPS staff.

If any additional information is obtained and if the requested Covered Service meets Medical Necessity criteria, DentaQuest's staff will approve the services requested within fifteen (15) days from the date it requested the additional information. If the resolution of the Pre-Appeal is to approve the request for a Covered Service, DentaQuest will give the affected health care provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the FFCHE Member or the Non-FFCHE Member's Medical Consenter. If no additional information is available or if the information provided does not meet Medical Necessity criteria for the Covered Service, DentaQuest will refer this information back to its Dental Director, or his/her designee, who will issue a final resolution to the Pre-Appeal within 48 hours of receiving the file from the DentaQuest staff. The Dental Director, or his/her designee, may reverse a proposed denial, or deny the requested Covered Service with guidance for the provision of acceptable alternative care options. If the resolution of the Pre-Appeal approves the request for the Covered Service, the DentaQuest staff will communicate the resolution verbally and in writing to the FFCHE Member or the Non-FFCHE Medical Consenter. DentaQuest will give the affected health care provider(s) written notice of the Pre-Appeal resolution on the same day it gives notice to the FFCHE Member or the Non-FFCHE Member's Medical Consenter.

Medicaid Member Appeals

A Medicaid Appeal is the formal process by which a Member or his or her representative request a review of DentaQuest's Action.

If a member, or member's representative, disagrees with a decision made to deny a covered service, they have the right to appeal. To do this, the appeal must be made orally or in writing within 60 days from the date of receipt of the notice of action. DentaQuest will acknowledge the receipt of the appeal within 5 business days and complete the appeal within 30 days.

What can I do if DentaQuest denies or limits my member's request for a covered service?

You, with the member's consent, can ask for an appeal in writing, or you can call and ask DentaQuest for an appeal. We will send

Current Dental Terminology © American Dental Association. All Rights Reserved

you and the member a one-page appeal form that you, the member, or someone else representing the member can fill out and return to us. Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

How will I find out if services are denied?

We will send you a Provider Determination Letter and the member will receive a Notice of Action Letter.

Timeframes for the Appeal Process/Expedited Appeals

If you have an emergency appeal, you can call us at 888.308.4766. We will respond within three (3) business days from the day we receive your request for appeal. DentaQuest will complete the entire standard Appeal process within 30 days after the receipt of the initial written or oral request for Appeal.

You or DentaQuest can ask for an extension of up to 14 calendar days if there is a need for more information in order to make a decision. DentaQuest will send you a written notice explaining the reason for the delay.

When does the member have the right to ask for an appeal?

The member has the right to request an appeal if he/she is not satisfied or disagrees with the action. An appeal is the process by which you and/or the member request a review of the action. A Member can request an Appeal for denial of payment for services in whole or in part.

To ensure continuation of currently authorized services, the member must file the appeal 10 calendar days following DentaQuest's mailing of the notice of the action or the intended effective date of the proposed action. The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

Can someone from DentaQuest help me file an Appeal?

Yes, please have the Member call our Member Call Center toll-free at 888.308.4766 to request assistance in filing an appeal. However, a member's option to request an External Medical Review and State Fair Hearing must be no later than 120 Days after DentaQuest mails the appeal decision notice.

The Member's option to request only a State Fair Hearing must be no later than 120 Days after DentaQuest mails the appeal decision notice.

Emergency Appeals

If the Member or Authorized Representative has requested an emergency appeal, DentaQuest will respond with a resolution within three (3) business days from the date of request for the appeal. Emergency Appeals do not require written and signed documentation from the Member or Authorized Representative. The verbal request is sufficient to process this appeal type.

If the request for an Emergency Appeal is denied by DentaQuest, the appeal request will follow the standard process and timeline requirements. DentaQuest will respond to the Member or Authorized Representative and follow up within two (2) calendar days with written notification of the denied Emergency Appeal request. Non-emergency appeals will be processed within thirty (30) calendar days from the date received.

Who can help me file an Appeal?

Please have the Member call our Member Call Center toll-free at 888.308.4766 to request assistance in filing an emergency appeal.

STATE FAIR HEARING INFORMATION

Can I ask for a State Fair Hearing?

If a Member, as a member of the dental plan, disagrees with the dental plan's decision, the Member has the right to ask for a

Current Dental Terminology © American Dental Association. All Rights Reserved

State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the dental plan telling them the name of the person you want representing you. A provider may be your representative. You or your representative must ask for the State Fair Hearing within 120 Days of the date on the dental plan's letter that tells of the decision you are challenging. If you do not ask for the State Fair Hearing within 120 Days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the dental plan at:

DentaQuest-TX Dental Program
Attn: Fair Hearing Coordinator
Stratum Executive Center 11044 Research Blvd
Building D, Suite D-400
Austin, TX 78759

Or call: 1-800-516-0165

If you ask for a State Fair Hearing within 10 Days from the time you get the hearing notice from the dental plan, you have the right to keep getting any service the dental plan denied, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 Days from the time you get the hearing notice, the service the dental plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the dental plan denied.

HHSC will give you a final decision within 90 Days from the date you asked for the hearing.

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of DentaQuest, disagrees with DentaQuest's decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to DentaQuest telling DentaQuest the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date DentaQuest mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Dental Contractor Internal Appeal Decision letter and mail or fax it to DentaQuest by using the address or fax number at the top of the form.
- Cal DentaQuest at 1-800-516-0165
- Email DentaQuest at CGATeam3@dentaquest.com
- Go in-person to a local HHSC office.

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from DentaQuest, the Member has the right to keep getting any service DentaQuest denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from DentaQuest, the service DentaQuest denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be

Current Dental Terminology © American Dental Association. All Rights Reserved

present at the State Fair Hearing. The Member can make both of these requests by contacting DentaQuest at CGATeam3@dentaquest.com or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling DentaQuest. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the Member must first complete DentaQuest's internal appeals process.

Program Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate. DentaQuest does not perform Member enrollment functions or determine eligibility of Members. Eligibility for Superior HealthPlan Membership is determined by the HHSC or its designee(s).

Providers may contact: https://www.yourtexasbenefitscard.com/

Verifying Eligibility

Member Identification Card

Members will receive a Superior ID card for the program they are eligible for. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if members have other health insurance.

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

Until the actual date of enrollment with Superior, Superior is not financially responsible for services the prospective Member receives, nor is Superior financially responsible for Members who have lost their Superior coverage. Superior distributes a Member ID Card to all eligible Members within five days of receipt of the Member's enrollment in Superior.

Sample of STAR Health 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.

DentaQuest 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 www.dentaquest.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative. A provider must verify member eligibility and/or authorizations for service.

Current Dental Terminology © American Dental Association. All Rights Reserved

Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the anticipated date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 844.776.8740. Once logged in, select "select patient from the portal menus then choose member eligibility search". You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records. **Be sure to verify eligibility on the date of service**. Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department at 844.776.8740 and press 1 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 Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member the Member's recipient identification number and date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service at 844.776.8740.
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, enter your NPI (National Provider Identification number).
5. When prompted, enter the last four (4) digits of your Tax ID number.
6. Does the member's ID **only have numbers** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **numbers and letters** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 844.776.8740. They will be able to assist you in utilizing either system.

Current Dental Terminology © American Dental Association. All Rights Reserved

Texas Dept of Family and Protective Services

Form 2085-B
August 2006
Page 1

DESIGNATION OF MEDICAL CONSENTER FOR NON-DFPS EMPLOYEE

SECTION 1: MEDICAL CONSENTER

The Texas Department of Family and Protective Services (DFPS), managing conservator of

Child's Name		Child's DFPS IMPACT Person ID	Medicaid No
Date of Birth	County	Court No	Cause No
Name of Judge	Phone Number of Court	Medical Consenter's DFPS IMPACT Person ID	

hereby designates (" the medical consenter ") to consent to the medical care including physical, dental, behavioral health, vision and allied health care (e.g., physical therapy, occupational therapy, speech therapy, dietetic services, etc.) for this child. With this designation, a 2085–A previously issued for this child is hereby revoked.

[Issue Form 2085-B only when the court has authorized DFPS to consent to medical care and the medical consenter or back-up medical consenter is a non-DFPS employee (e.g., live-in caregiver, emergency shelter or CPA professional employee). A combination of Forms 2085-B and C may be used. Complete Form 2085-B as follows:

- *Enter the name of the medical consenter in Section 1. Both parents may be designated in Section 1 (e.g., birth parents, kinship caregivers, foster parents, pre-consummated adoptive parents, cottage parents in a basic childcare facility or home and community-based (HCS) support family caregivers).*
- *Enter the name of the back up medical consenter in Section 2. Both parents may be designated in Section 2 (e.g., relatives, alternate cottage parents in a basic childcare facility).*

If the medical consenter and/or back up medical consenter are affiliated with a residential provider (e.g., CPA, emergency shelter, basic childcare facility or home and community based services (HCS) provider), a representative of the residential provider must sign the form.]

This medical consenter and back up medical consenter must cooperate with DFPS as stated below. All references in this document to medical consenters also apply to back up medical consenters. Failure to cooperate with DFPS may be a basis for revoking the designation.

1. **Selection of/Change of Primary Care Provider (PCP).** When a new child is enrolled in STAR Health or an existing child changes placement, STAR Health will auto-assign a PCP. The medical consenter can change the PCP at any time by calling STAR Health at the number provided under #14 on this form or mailing a PCP change form to STAR Health. Only the medical consenter can change the PCP. If the medical consenter is not the child's live in caregiver, the medical consenter will need to coordinate with the caregiver on the selection of a PCP.

   The medical consenter may select a PCP who is not a licensed and enrolled Texas Health Steps (THSteps) provider but must ensure that the child receives appropriate THSteps Checkups according to #2, below. (See #14, below, to determine whether a child is covered by STAR Health.)

2. **Preventive Care/Texas Health Steps Checkup.** The medical consenter must ensure that the child receives THSteps Checkups by licensed and enrolled THSteps providers as follows:
   - An initial THSteps Checkup within:

Current Dental Terminology © American Dental Association. All Rights Reserved

- 14 days of enrollment in STAR Health for a child under one year of age
- 21 days of enrollment in STAR Health for a child over one year of age

- An annual THSteps Checkup every 13 months from the date of the last Checkup

The medical consenter must ensure that a child one year of age or older receives Dental Checkups by licensed and enrolled THSteps providers as follows:

- An initial Dental Checkup within 60 days of enrollment in STAR Health
- A Dental Checkup every 7 months from the date of the last Dental Checkup

The medical consenter will discuss the plans to obtain these screenings and services with the child's DFPS caseworker during the development and review of the child's plan of service and the submission of the Summary of Medical Care described under #12, below.

A THSteps Checkup is defined in the current Medicaid Procedure Manual as one that follows the American Academy of Pediatrics Periodicity Schedule. The THSteps Periodicity Table includes:

- Well child examinations by a licensed and enrolled THSteps provider;
- Sensory screening (e.g., vision, hearing),
- Developmental/behavioral assessment,
- Immunizations,
- Laboratory testing for screening purposes (e.g., blood work, urinalysis, TB testing, STD screening, pelvic exam),
- Anticipatory guidance, and
- Dental Checkups by a licensed and enrolled THSteps provider.

When the medical consenter consents to a (THSteps) Checkup provided by a licensed and enrolled THSteps provider, the medical consenter is not required to discuss the consent for medical care with the child's caseworker or the caseworker's supervisor, but is required to include the information on the Summary of the Child's Medical Care.

3. **Major Medical Care**. When the medical consenter consents to major medical care provided by a licensed health care provider, the medical consenter must consult with the child's DFPS caseworker or the DFPS caseworker's supervisor before consenting. Major medical care includes:

- any surgical procedure;
- any treatment the child's physician considers dangerous; or
- any other medical treatment that may be threatening to the child's life or long-term health.

However, the medical consenter provides the consent to the child's health care provider, verbally or in writing as required by the health care provider.

4. **Emergency Care**. The medical consenter may consent to emergency medical care by a licensed health care provider without informing the child's DFPS caseworker or the DFPS caseworker's supervisor, if there is not enough time to contact them in advance. The medical consenter must notify the child's DFPS caseworker, the caseworker's supervisor, or the emergency on-call caseworker through the abuse hotline, of the emergency care, immediately following the provision of emergency care, but no later than the next business day after the initial treatment.

5. **Admission to Mental Health Facility.** Except in an emergency or when a court orders mental health treatment for a child, the medical consenter must coordinate an admission of a child to a mental health facility with the child's DFPS caseworker or the DFPS caseworker's supervisor. The medical consenter consents to treatment and each psychotropic medication

Current Dental Terminology © American Dental Association. All Rights Reserved

prescribed for the child. However, DFPS staff must consent to the admission of the child to the mental health facility.

When a child is admitted to a mental health facility in an emergency or under a court order, the medical consenter notifies the child's DFPS caseworker or the DFPS caseworker's supervisor immediately following the admission, if there is no time to notify them in advance, and no later than the next business day after the admission.

[A mental health facility is defined as a state hospital, a private psychiatric facility, a mental health facility licensed or operated by DSHS that provides 24 hour inpatient mental health treatment (does not include an RTC licensed by DFPS) and a local mental health authority or a facility operated by or under contract with a local mental health authority (e.g., Harris County Psychiatric Center in Houston and the University of Texas Medical Branch at Galveston)].

6. **Psychotropic Medications and Schedule II–V Drugs.** The medical consenter may consent to the administration of psychotropic medications and/or Schedule II-V drugs (controlled substances) when prescribed by a licensed health care provider. However, the medical consenter must notify the child's DFPS caseworker or the caseworker's supervisor by close of business on the next business day. This notification must be in writing, by email or other written communication.

7. **Extraordinary Medical Procedures.** The medical consenter may not consent to extraordinary medical procedures, which may be governed by other provisions of the law. If a healthcare provider recommends such a procedure, the medical consenter must notify the child's DFPS caseworker or the caseworker's supervisor as soon as possible and no later than the next business day. DFPS staff may also need to consult with the child's attorney or guardian ad litem, judge, etc. Examples of extraordinary medical procedures include the withholding or withdrawal of life sustaining treatment, organ donation, abortion, electroconvulsive therapy, aversion therapy and any experimental treatment or clinical trials.

8. **Notification of Significant Medical Conditions.** The residential provider and/or medical consenter must immediately notify the child's DFPS caseworker or the DFPS caseworker's supervisor of any significant medical conditions, so DFPS can notify a child's parents whose rights have not been terminated.

Examples of a serious medical condition include injuries or illnesses that:

- Are life threatening, or
- Have potentially serious long-term health consequences, including hospitalization for surgery or care other than minor emergency.

9. **Drug-testing**. The medical consenter must consult the child's caseworker or the caseworker's supervisor before consenting to drug-testing for possible substance abuse.

10. **HIV-Testing**. The medical consenter must consult with the child's caseworker or the caseworker's supervisor to obtain approval from the DFPS program director before consenting to any test designed to detect the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome (AIDS). **Exception:** Children who ask to be tested, have the right to be tested without the designee's consent; however, the child must be offered information and counseling. The medical consenter must also ensure that any duly approved HIV-testing performed on the child conforms to the policies specified in 40 Texas Administrative Code (TAC) §§700.1401-700.1406 (Subchapter N, AIDS Policies for Children in DFPS Conservatorship).

Current Dental Terminology © American Dental Association. All Rights Reserved

11. **Participation in Medical Appointment.** The medical consenter must participate in each appointment of the child with the provider of medical care, as follows, unless otherwise required by the health care provider:

Preventive Care/THSteps Checkup (as defined under #2, above). The medical consenter or back up medical consenter may participate by providing written consent to the residential provider or another person to take the child for the appointment, unless the health care providers requires the consenter's participation in person or by phone. The medical consenter or back up medical consenter provides this consent by issuing Form 2085-D to the person taking the child to the appointment.

Ongoing Behavioral Health Therapy and Allied Health Services. The medical consenter or back up medical consenter must approve the behavioral or allied health care plan and monitor the progress of the child. The medical consenter is not required to attend every appointment but should participate when requested by the therapist. These therapy/services include dietary services, occupational, physical, speech or other therapy.

Other Medical Care. The medical consenter or back up medical consenter must attend the appointment or participate by phone, as specified by the health care provider. This medical care includes medical appointments for:

- Physical health,
- Dental treatment (e.g., fillings, crowns), and
- Review of the progress of children prescribed psychotropic medications .

12. **Summary of Child's Medical Care.** The medical consenter must complete the Summary of Child's Medical Care form and provide it to the caseworker before each court hearing, as requested by the caseworker. The medical consenter includes a summary of all medical care provided to the child, including preventive care, major medical care, emergency care and medical care for common childhood illnesses and minor injuries, such as ear infections or a minor laceration.

13. **Acknowledgement.** The medical consenter acknowledges having received training on informed consent by presenting a certificate of completion of Medical Consent Training. The medical consenter also agrees to provide a copy of this Designation of Medical Consenter For Non-DFPS Employees form to all of the child's health care providers.

14. **Mandatory STAR Health Enrollment** The medical consenter must seek medical care from a STAR Health provider, unless the child is placed in a nursing home , intermediate care facility for mental retardation (ICF-MR) or out-of-state.

For children covered by STAR Health, the medical consenter may obtain information about the child's health care by calling STAR Health Member Services: 1-866-912-6283
This information may include the types of services available to the child through this STAR Health or assistance in locating a doctor, nurse, dentist or other specialist in the program.

If a pharmacy refuses to accept Form 1027A, Medical Eligibility Verification, the medical consenter should request that the pharmacy contact the Vendor Drug Help Desk. The pharmacy should be aware of the phone number for the Vendor Drug Help Desk. The pharmacy may submit claims using the child's DFPS IMPACT Person Identification (PID) number to submit pharmacy claims, if the child has not yet been assigned a Medicaid number.

For children placed out-of-state, the medical consenter contacts the child's caseworker for questions about healthcare coverage.

Current Dental Terminology © American Dental Association. All Rights Reserved

15. **Enrollment in STAR Health Clinical Program.** The medical consenter must notify the child's DFPS caseworker or the caseworker's supervisor of enrollment of a child in STAR Health Service Management and/or Disease Management programs by the next business day after enrollment.

16. **Denial of STAR Health Services.** The medical consenter must notify the child's DFPS caseworker or the caseworker's supervisor by the next business day after the receipt of a letter from STAR Health denying a health care service and offering the right to appeal.

17. **Access to Medical Records and Protected Health Information (PHI).** The medical consenter is authorized to access, receive, and review the child's medical records. Furthermore, the medical consenter may obtain free copies or authorize the release of the child's medical records to the extent necessary to obtain services for the child.

The medical consenter is entitled to obtain protected health information (PHI) maintained by STAR Health. To obtain PHI, the medical consenter must provide his or her DFPS IMPACT Person Identification (PID). The medical consenter's PID is available in the heading of this form and may be obtained from the child's DFPS caseworker or the caseworker's supervisor.

18. **Health Passport.** The medical consenter is authorized to access the child's Health Passport. The Health Passport is a web-based health information tool (but not a medical record) located at www.fostercarerx.com. When accessing the Health Passport for the first time, the medical consenter must register using his or her DFPS IMPACT Person Identification (PID) number and other identifying information. The medical consenter's PID is available in the heading of this form and may be obtained from the child's DFPS caseworker or the caseworker's supervisor. When entering the health passport for the first time, the medical consenter will create a password and no longer need his or her PID to access the Health Passport.

Once registered and logged on using his or her password, the medical consenter may access the child's health information by entering the child's social security number, Medicaid number, or DFPS IMPACT PID (also available in the heading of this form). If the medical consenter has difficulty accessing the health passport, he or she may email TX_PassportAdmin@centene.com or call 866-714-7996 for technical assistance.

The Medical Consenter must use discretion when printing the Health Passport, always safeguarding the privacy of the child and the confidentiality of Protected Health Information. The Medical Consenter may **NOT** distribute copies of the Health Passport or sections of the Health Passport to other persons or entities.

19. **Education Portfolio.** The medical consenter is entitled to access the child's education portfolio as needed to become knowledgeable of health care services provided by the independent school district. The medical consenter may obtain this information from the child's DFPS caseworker.

Current Dental Terminology © American Dental Association. All Rights Reserved

SECTION 2: BACK UP MEDICAL CONSENTER

(Complete the following Section only if the back up medical consenter is a non-DFPS employee.) DFPS hereby designates _____ as back up medical care for this child. The back up medical consenter must also cooperate with DFPS in the manner described in Section 1.

SECTION 3: SIGNATURES

Signature – First Primary Medical Consenter Section 1	Date	Telephone Number
Signature – Second Primary Medical Consenter Section 1	Date	Telephone Number
Signature—First Back up Section 2	Date	Telephone Number
Signature Second Back up Section 2	Date	Telephone Number
Signature – Representative of Residential Provider for Medical Consenter or Back Up Medical Consenter Section 2, if affiliated with residential provider	Date	Telephone Number
Signature –DFPS Caseworker	Date	Telephone Number
Signature - DFPS Supervisor	Date	Telephone Number

Note to DFPS staff: Forms 2085 B, C and D are the only authorizations for medical care that the child's caseworker and supervisor may sign without consulting the DFPS regional attorney.

Note to Health Care Providers: **If you have any medical concerns regarding this child, please contact the DFPS caseworker or supervisor (see contact information in the signature line above) or the judge (see contact information in the heading on Page 1).** The health care provider may also contact the judge if he or she has any concerns about the decision(s) of the medical consenter.

Current Dental Terminology © American Dental Association. All Rights Reserved

What is a Medical Consenter?

A medical consenter is the person whom a court has authorized to consent to medical care for a child in conservatorship. The medical consenter may be the child's foster parent, the child's relative, or a person named by the Department of Family and Protective Services. A medical consenter may also be a child in conservatorship of at least 16 years of age, if a court says the child has the capacity to consent to medical care.

What is the role of a Medical Consenter?

The role of a medical consenter includes consenting to the child's medical care and participating in the child's medical appointments. Medical care means "health care and related services." This may include medical, dental, behavioral, and surgical treatment.

CHILDREN'S MEDICAID DENTAL SERVICES MEMBER RIGHTS AND RESPONSIBILITES MEMBER RIGHTS

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your dental records and discussions with your dentists will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and dentist. You have the right to change to another plan or dentist in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your dental plan and your dentist.
    b. Choose any dental plan you want that is available in your area and choose your dentist from that plan.
    c. Change your dentist.
    d. Change your dental plan without penalty.
    e. Be told how to change your dental plan or your dentist.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your dentist explain your dental care needs to you and talk to you about the different ways your dental care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your dentist in deciding what dental care is best for you.
    b. Say yes or no to the care recommended by your dentist.
5. You have the right to use each available complaint and appeal process through the Dental Contractor and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
    a. Make a complaint to your dental plan or to the state Medicaid program about your dental care, your dentist or your dental plan.
    b. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
    c. Get a timely answer to your complaint.
    d. Use the DentaQuest's appeal process and be told how to use it.
    e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a dental professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get dental care in a timely manner.
    c. Be able to get in and out of a dental care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your dentist and when talking to your dental plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

Current Dental Terminology © American Dental Association. All Rights Reserved

e. Be given information you can understand about your dental plan rules, including the dental care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
2. Learn what choices of dental plans are available in your area. You must abide by the dental plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your dental plan's rules and Medicaid rules.
    b. Choose your dental plan and a dentist quickly.
    c. Make any changes in your dental plan and dentist in the ways established by Medicaid and by the dental plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your dentist first for your non-emergency dental needs.
    g. Be sure you have approval from your dentist before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your dentist about your health.
    b. Talk to your dentist about your health care needs and ask questions about the different ways your dental care problems can be treated.
    c. Help your dentist get your dental records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your dental health. That includes the responsibility to:
    a. Work as a team with your dentist in deciding what dental care is best for you.
    b. Understand how the things you do can affect your dental health.
    c. Do the best you can to stay healthy.
    d. Treat dentists and staff with respect.

STAR HEALTH MEMBER RIGHTS AND RESPONSIBILITES

MEMBER RIGHTS:

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your dentists and other providers.
2. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a dental professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get dental care in a timely manner.
    c. Be able to get in and out of a dental provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to DentaQuest. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
3. You have the right to know how your dentists are paid. You have a right to know about what those payments are and how they work.
4. You have the right to know how DentaQuest decides about whether a service is covered and/or medically necessary. You have the right to know about the people in DentaQuest's office who decide those things.
5. You have the right to know the names of the dentists and other providers enrolled with DentaQuest and their addresses.

Current Dental Terminology © American Dental Association. All Rights Reserved

6. You have the right to choose a primary dentist from a list of dentists that is large enough so that you can get the right kind of care when you need it.
7. You have the right to speak for your child in all treatment choices.
8. You have the right to get a second opinion from another dentist enrolled with DentaQuest about what kind of treatment your child needs.
9. You have the right to be treated fairly by DentaQuest, dentists and other providers.
10. You have the right to talk to your dentists and other providers in private, and to have your child's dental records kept private. You have the right to look over and copy your dental records and to ask for changes to those records.
11. You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
12. You have the right to use each available complaint and appeal process through the STAR Health MCO and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
    a. Make a complaint to DentaQuest or to the state Medicaid program about your child's dental care, your provider or DentaQuest.
    b. Get a timely answer to your complaint.
    c. Use the HHSC claims administrator's and DentaQuest's appeal process and be told how to use it.
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
13. Your child has the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force your child to do something he/she doesn't want to do, or is to punish your child.
14. You have a right to know that you are not responsible for paying for covered services provided to your child. Dental providers cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

You and DentaQuest both have an interest in seeing your child's dental health improve. You can help by assuming these responsibilities.

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you don't understand your rights.
    c. Learn about what DentaQuest does and does not cover. You must read your Member Handbook to understand how the rules work.
2. You must abide by DentaQuest's policies and procedures and Medicaid policies and procedures.That includes the responsibility to:
    a. Learn and follow DentaQuest's and Medicaid rules.
    b. Keep your scheduled appointments.
    c. Cancel appointments in advance when you can't keep them.
    d. Always contact your primary dentist first for your non-emergency dental needs.
3. You must try to follow healthy habits, such as encouraging your child to exercise, to stay away from tobacco, and to eat a healthy diet.
4. You must share information about your child's dental health with your child's dentist and learn about service and treatment options. That includes the responsibility to:
    a. Talk to your providers about your child's dental care needs and ask questions about the different ways your child's dental care problems can be treated.
    b. Help your providers get your child's dental records.
    c. Become involved in the dentist's decisions about your child's treatments.
    d. Work together with DentaQuest's dentists and other providers to pick treatments for your child that you have all agreed upon.
5. If you have a disagreement with DentaQuest you must try first to resolve it using DentaQuest's complaint process.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Statement of Provider Rights and Responsibilities

Providers shall have the right and responsibility to:

Current Dental Terminology © American Dental Association. All Rights Reserved

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 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 DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by 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.
7. To be informed of the status of their credentialing or recredentialing application, upon request.
8. Verify member eligibility, benefits and authorizations required for services to be performed.

FRAUD REPORTING

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid or CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a Medicaid or CHIP Dental ID.
- Using someone else's Medicaid or CHIP Dental ID.
- **Not telling the truth about the amount of money or resources he or she has to get benefits.**

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184; or
- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form.
- You can report directly to your health plan:

DentaQuest-TX Superior Dental Services
Attention: Utilization Review Department
12121 North Corporate Parkway
Mequon, WI 53092

Toll free at 1-800-237-9139

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider.
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it.
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation.
  - Dates of events.
  - Summary of what happened.
- When reporting about someone who gets benefits, include:
  - The person's name.
  - The person's date of birth, Social Security number, or case number if you have it.
  - The city where the person lives.
  - Specific details about the waste, abuse, or fraud.

Current Dental Terminology © American Dental Association. All Rights Reserved

Claim Submission Procedures (claim filing options)

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

- Electronic claims via DentaQuest's website (www.dentaquest.com).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims (ADA Claim Form 2018, 2019, or newer)

Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 844.776.8740. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at 800.417.7140 or via e-mail at: EDIteam@greatdentalplans.com

Electronic Authorization Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Pre-Authorizations 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 pre-authorizations via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 844.776.8740. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

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

EDIteam@greatdentalplans.com

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.

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

Current Dental Terminology © American Dental Association. All Rights Reserved

system.

Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

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.

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual 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 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.

Paper Claim Submission

- Claims must be submitted on 2018, 2019, or later ADA approved claim forms.
- 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
12121 N. Corporate Parkway
Mequon, WI 53092

For questions, providers may contact DentaQuest Provider Services at 844.776.8740.

Coordination of Benefits (COB)

Medicaid is the payer of last resort. Providers should ask Members if they have other dental insurance coverage at the time of their appointment. When Medicaid is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits

Current Dental Terminology © American Dental Association. All Rights Reserved

(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 the Medicaid fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

Member Billing Restrictions

Providers may not bill Members directly for Covered Services. DentaQuest reimburses only those services that are medically necessary and a Covered benefit in the respective program the Member is enrolled in. Medicaid Members do not have co-payments.

Member Acknowledgement Statement

A Provider may bill a Member for a claim denied as not being medically necessary or not a part of a Covered service if both of the following conditions are met:

- A specific service or item is provided at the request of the client
- If the Provider obtains a written waiver from the Member prior to rendering such service. The Member Acknowledgment Statement reads as follows:

  "I understand that, in the opinion of (Provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Assistance Program as being reasonable and medically necessary for my care. I understand that DentaQuest through its contract with Superior and HHSC determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Private Pay Form (Non-Covered Services Disclosure Form)

There are instances when the dentist may bill the Member. For example, if the Provider accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for payment for all services. In this situation, it is recommended that the Provider use a Private Pay Form. It is suggested that the Provider use the Member Acknowledgement Statement listed above as the Private Pay Form, or use the DentaQuest Non-Covered Services Disclosure Form. Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider could not ask for payment from a Member.

Filing Limits

DentaQuest must receive your claim requesting payment of services within 95 days from the date of service. Any claim submitted beyond the timely filing limit will be denied for "untimely filing." If a claim is denied for "untimely filing"; the member cannot be billed. If Superior/DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

Clean Claim payment must be made by DentaQuest within 30 days.

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 Customer Contact Center Representative analyzes any claim conditions that would result in non- payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service department at 844.776.8740 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

Current Dental Terminology © American Dental Association. All Rights Reserved

information and an allowable fee by date of service for each service rendered.

Direct Deposit

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

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

- Complete and sign the Direct Deposit Authorization Form (see Attachment A-20)
- Attach a voided check to the form. The authorization cannot be processed without a voided check.
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.
    - Via Fax – 262.241.4077
    - Via Mail:

DentaQuest TX Superior
12121 North Corporate Parkway
Mequon, WI 53092
ATTN: Provider Enrollment Department

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

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 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
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.

Special Access Requirements

Interpreter/Translation Services

DentaQuest is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its Members. In order to meet this need, DentaQuest provides or coordinates the following:

- Our Member Services and Member Advocate department is staffed with Spanish and English bilingual specialists.
- Trained professional language interpreters, including American Sign Language, can be made available face-to-face at your office if necessary, or via telephone, to assist Providers with discussing technical, medical, or treatment information with Members as needed.
- Language Services Associates will be available in 140 languages to assist Providers and Members in communicating with each other when there are no other translators available for the language.
- TTY access for Members who are hearing impaired: 711

Reading/Grade Level Consideration

An estimated 40–44 million Americans are functionally illiterate and another 50 million are only marginally literate. Nearly half of the functionally illiterate live in poverty and one fourth report physical, mental or health conditions that prevent them from participating fully in work, school or housework. A study of patients at two public hospitals found that 35 percent of the English-

Current Dental Terminology © American Dental Association. All Rights Reserved

speaking and 62 percent of the Spanish-speaking patients had inadequate or marginal functional health literacy, with more than 81 percent of the elderly groups having limited health literacy. Because of this, DentaQuest understands that many of our members may have limited ability to understand and read instructions. Yet, most people with literacy problems are ashamed and will try to hide them from Providers. Low literacy can mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Member materials should be written at a fourth to sixth grade reading level. The guidelines provided for communication with interpreters are also good guidelines for communicating with members with limited literacy, especially asking the member to repeat your instructions. Do not assume that the member will be able to read instructions or a drawing/diagram for taking prescription medicines or understanding of treatment. Above all else, be sensitive to the embarrassment the Member may feel about limited literacy. Please contact us for interpretation services should there be a language barrier.

Cultural Sensitivity

DentaQuest places great emphasis on the wellness of its Members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Provider's relationship with patients and in the long run the health and wellness of the patients themselves.

Following is a list of principles for health care Providers, to include knowledge, skills and attitudes, related to cultural competency in the delivery of health care services to DentaQuest Members:

Knowledge

- Provider's self understanding of race, ethnicity and influence
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress, socioeconomic status
- Understanding of the cultural differences within minority groups
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network
- Understanding of the differences between "culturally acceptable" behavior of psycho-pathological characteristics of different minority groups
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients
- Understanding of the cultural beliefs of health and help seeking patterns of minority patients
- Understanding of the health service resources for minority patients
- Understanding of the public health policies and its impact on minority patients and communities

Skills

- Ability to interview and assess minority patients based on a psychological/social/ biological/ cultural/ political/ spiritual model
- Ability to communicate effectively with the use of cross-cultural interpreters
- Ability to diagnose minority patients with an understanding of cultural differences in pathology
- Ability to avoid under diagnosis or over diagnosis
- Ability to formulate treatment plans that are culturally sensitive to the patient and family's concept of health and illness
- Ability to utilize community resources (church, community-based organizations (CBOs), self-help groups) • Ability to ask for consultation

Attitudes

- Respect the "survival merits" of immigrants and refugees
- Respect the importance of cultural forces
- Respect the holistic view of health and illness
- Respect the importance of spiritual beliefs
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines
- Be aware of transference and counter transference issues

DentaQuest encourages and advocates for providers to provide culturally competent care for its Members. Providers are also encouraged to participate in training provided by other organizations. You can visit www.hrsa.gov/healthliteracy/training.htm for an online training course developed by the Health Resources and Services Administration (HRSA) and earn CEU and/or CME credits

Current Dental Terminology © American Dental Association. All Rights Reserved

Special Health Care Needs

Members with Special Health Care Needs may have direct access to specialists as appropriate for the Member's condition and identified needs. If you cannot locate a specialist in your area, you may call DentaQuest's Provider Call Center's toll-free telephone number at 844.776.8740 to facilitate a Member referral to a specialist.

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.

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.

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.

Current Dental Terminology © American Dental Association. All Rights Reserved

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 and Transitional 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 (age 16-19 years of age) 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.

Current Dental Terminology © American Dental Association. All Rights Reserved

Clinical Criteria

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

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

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

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

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

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

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

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

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

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

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.

Criteria for Dental Extractions

Not all procedures require authorization.

Current Dental Terminology © American Dental Association. All Rights Reserved

Documentation needed for authorization procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization 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 (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with four or more extractions in the same quadrant will be covered subject to consultant review.

Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

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

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

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

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

Current Dental Terminology © American Dental Association. All Rights Reserved

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

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs 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.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.

Current Dental Terminology © American Dental Association. All Rights Reserved

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

Other Considerations

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

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

Criteria

In most cases, OR will be authorized (for procedures covered by 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 authorization 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, resent 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.

Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.

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

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

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer

Current Dental Terminology © American Dental Association. All Rights Reserved

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.
- 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.

In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Authorizations for removable prosthesis will not meet criteria:

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

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 12 months after insertion. After 12 months of denture placement.
- A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted
- 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.

Current Dental Terminology © American Dental Association. All Rights Reserved

- 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 pre-authorization of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

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 authorization 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.

Authorization requirements:

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

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.

Current Dental Terminology © American Dental Association. All Rights Reserved

Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for general anesthesia or IV sedation.
- Treatment rendered under emergency conditions, when authorization 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 (e.g. 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 5 years old and younger with extensive procedures to be accomplished.

For Members Ages Six and Under

Prior Authorization Criteria

Requests for prior authorization must include, but are not limited to, the following client- specific documents and information:

- A completed Criteria for Dental Therapy Under General Anesthesia form
- A completed Prior Authorization Claim Form. This must include CDT code(s) for all procedures to be performed and D9222/D9223 or D9500 (a DentaQuest specific code that indicates Medical Anesthesia Services) based on place of service and anesthesiologist type
- Location where the procedure(s) will be performed (office or outpatient)
    - Tentative date of service if outpatient request or in office using a medical anesthesiologist
- Narrative unique to the client, detailing reasons for the proposed level of anesthesia (indicate procedure code D9222/D9223 or D9500). The narrative must include history of prior treatment, failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and

Current Dental Terminology © American Dental Association. All Rights Reserved

surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).

- Diagnostic quality radiographs or photographs
    - When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For these special cases that receive authorization, diagnostic quality labeled radiographs or photographs will be required for payment and will be reviewed by the DentaQuest Dental Director.

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Note: In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post- treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the DentaQuest Dental Director.

A copy of the Criteria for Dental Therapy under General Anesthesia form must be maintained in the client's dental record. The client's dental record must be available for review by representatives of the Health and Human Services Commission (HHSC) or its designee.

The following outlines the process based on place of service (in office / outpatient) and anesthesiologist type (dental / medical).

Dental Therapy under General Anesthesia - In Office

1. Treating Dentist using Dental Anesthesiologist

- Is responsible for obtaining prior authorization from DentaQuest and is responsible for providing the anesthesia prior authorization information to the dental anesthesiologist
- Submits one D9222, appropriate units of D9223, and CDT code(s) that will be performed under general anesthesia for prior authorization DentaQuest will determine medical necessity of the general anesthesia based on the submitted treatment plan and required documentation
- DentaQuest will notify the treating dentist of the determination via a Provider Determination Letter (PDL). For services that are approved, the treating dentist would then provide a copy of the PDL to the dental anesthesiologist. Code D9223 will indicate the DentaQuest determination and will be either approved or denied. While we are reviewing the necessity of the general anesthesia on the overall treatment plan, certain services on the PDL will indicate Service Not Reviewed if they do not typically require authorization under DentaQuest policy. Failure to submit per Prior Authorization Criteria as outlined above will result in a denial. See example below, indicating the anesthesia service (D9222/ D9223) has been approved.

D9222	deep sedation/general anesthesia – first 15 minutes	1	Approved	Advisory
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	1	Approved	Advisory

Dental Anesthesiologist

- Upon completion of the approved services, the dental anesthesiologist will submit claims to DentaQuest
- The DentaQuest approved authorization number from treating dentist must be in "Box 35" of the claims form or in

Current Dental Terminology © American Dental Association. All Rights Reserved

the notes section of the portal

- Must submit one D9222 and appropriate units of D9223 with supporting documentation
- Must have a current level 4 permit
- Treating Dentist
- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to DentaQuest

2. Treating Dentist using Medical Anesthesiologist

- Is responsible for obtaining prior authorization from DentaQuest and is responsible for providing the anesthesia prior authorization information to the medical anesthesiologist
- Submits D9500 and CDT code(s) that will be performed under general anesthesia for prior authorization
- DentaQuest will determine medical necessity of the general anesthesia based on the submitted treatment plan and required documentation.
- DentaQuest will notify the treating dentist of the determination via a Provider Determination Letter (PDL). For anesthesia that is approved, the treating dentist would then provide a copy of the PDL to the medical anesthesiologist. Code D9500 will indicate the DentaQuest determination and will be either approved or denied. While we are reviewing the necessity of the general anesthesia on the overall treatment plan, certain services on the PDL will indicate Service Not Reviewed if they do not typically require authorization under DentaQuest policy. Failure to submit per Prior Authorization Criteria as outlined above will result in a denial. See example below, indicating the medical anesthesia service (D9500) has been approved.

D2930	prefabricated stainless steel crown - primary tooth	Tooth T	1	Service Not Reviewed	Advisory
D9500	medical anesthesia services		1	Approved	Advisory

Medical Anesthesiologist

- Is responsible for submitting a separate prior authorization request to the member's MCO along with the approved DentaQuest PDL
- The MCO reviews submitted documentation from DentaQuest to determine whether medical anesthesia is approved or denied
- Upon completion of the approved services, the medical anesthesiologist will submit claims to the member's MCO using the appropriate CPT code(s)

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to DentaQuest

Please remember that the provider who submits the authorization for the dental therapeutic services must be the provider that performs the services. If the authorized provider does not perform the service, claims will deny. In the event the authorized provider is unable to perform the services, DentaQuest must be notified to update the

Current Dental Terminology © American Dental Association. All Rights Reserved

authorization prior to the services being performed. This is not applicable to the anesthesiologist.

Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

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

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

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

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

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

Criteria

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

Current Dental Terminology © American Dental Association. All Rights Reserved

Appendix A -

STAR HEALTH (FOSTER CARE)

Program Benefits

- No annual maximum
- Statewide Medicaid dental benefits (see Exhibit A)
- No co-payments
- Orthodontics (medically necessary cases)

Member Eligibility

The following groups are eligible to participate in the STAR Health program:

- Children and young adults in Department of Family and Protective Services (DFPS) conservatorship.
- Emancipated minors or Members age 18-22 who voluntarily agree to continue in a foster care placement.
- Young adults who have exited care and are participating in the Medicaid Transitional Foster Care Youth (MTFCY) Program ages 18-21.
- Former Foster Care in Higher Education (FFCHE) who are at least 21 years of age attending college or technical school within the state of Texas may be eligible for STAR Health coverage through the month of their 23rd birthday.

Members excluded from the STAR Health Program are children who are:

- In the Texas Youth Commission (TYC)
- In the Texas Juvenile Probation Commission (TJPC)
- From other states placed in Texas
- In Medicaid-paid facilities such as nursing homes, state schools or Intermediate Care Facilities for Mentally Retarded Persons (ICF-MR)
- Dual eligible clients (Medicaid/Medicare)
- Placed outside of Texas

Clients in a waiver program will be enrolled in STAR Health, but receive waiver services from the C waiver program. These waiver programs include:

- Consolidated Waiver Program(CWP)
- Community Living Assistance and Support Services (CLASS)
- Home and Community-based Services (HCS)
- Deaf-Blind Multiple Disabilities (DBMD)
- Medically Dependent Children Program (MDCP)
- Texas Home Living (TxHmL)

Please note: Newborns born to FFCHE Members are not eligible for the STAR Health program. Newborns will be automatically enrolled into Medicaid. Please refer the FFCHE member to locate the nearest Medicaid office. For specific questions on the FFCHE program and eligibility requirements, please refer them to HHSC at 800-248-1078.

Coordination with Texas Department of Family and Protective Services

Provider must coordinate with DFPS and a Member's Medical Consenter and/or Caregiver for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS. As a STAR Health provider for members you may be called upon to do the following:

- Schedule appointment within 14 days of the requested appointment or earlier as requested by DFPS.
- Provide dental treatment records
- Testify in court for child protection litigation
- Adhere to DFPS policy related to medical consenter and the release of confidential information
- Report any recognition of abuse and neglect, and appropriate referral to DFPS

Current Dental Terminology © American Dental Association. All Rights Reserved

If the assessment involves a dental evaluation you will be notified on how comply with DFPS's request, the requirements mandating delivery of assessment and how to coordinate the expeditious release of the assessment.

Coordination for Services Not Directly Provided Through Superior HealthPlan

There are several services that are available STAR Health based on their eligibility. The services listed in the following are accessed outside of Superior HealthPlan, but are available services to STAR Health Members. These services are as follows:

- Mental Health Rehabilitation Services
- Early Childhood Intervention (ECI) targeted case management and developmental
- Rehabilitative services
- MHMR Targeted Case Management
- Personal Care Services
- Pregnant Women and Infants Case Management (PWI)
- Texas Health Steps Medical Case Management
- Texas School Health and Related Services (SHARS)
- Texas Commission for the Blind (TCB) Case Management
- Tuberculosis (TB) Services Provided by HHSC-approved Providers (Directly Observed Therapy and Contact Investigation)
- Women, Infants and Children nutrition program (WIC)
- Texas Agency Administered Programs and Case Management Services
- Vendor Drug Program (for prescription drugs not supplied in the Provider's office or Hospital setting)
- Medical Transportation Services available through the Texas Health and Human Services Commission
- DADS Hospice Services and
- Essential Public Health Services

All network Providers are encouraged to refer to and coordinate services with the above agencies.

Current Dental Terminology © American Dental Association. All Rights Reserved

Definitions

- **Administrative Services Contractor** (or "ASC") means an entity performing Medicaid managed care administrative services functions, including enrollment or claims payment functions, under contract with HHSC.

- **Caregiver** means the DFPS-authorized caretaker for a Foster Care Covered Person, including the Foster Care Covered Person's foster parent(s), relative(s), or 24-hour child-care facility staff.

- **Clean Claim** means a claim submitted by a Participating Health Care Provider for medical care or health care services rendered to an FC Covered Person, with documentation reasonably necessary for DentaQuest to process the claim. DentaQuest may not require a Participating Health Care Provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

- **Covered Services** means health care services SHPN (as defined below) must arrange to provide to FC Covered Persons, including all services required by the Foster Care Program Contract, state and federal law, and all value-added services negotiated by SHPN and HHSC. Covered Services include, without limitation, acute care, behavioral health services, dental services, vision services, and court-ordered medical services.

- **DFPS** means the Texas Department of Family and Protective Services or its successor agency.

- **Emergency Dental Care** means procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures required to prevent imminent loss of teeth; and treatment of injuries to the teeth and supporting structures. Routine restorative procedures and root canal therapy are not emergency services.

- **Emergency Care** means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

- **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part;
    - Serious disfigurement; or
    - Serious jeopardy to the health of a pregnant woman or her unborn child.

- **Emergency Services** means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Foster Care Program Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

- **Foster Care Covered Person** or FC Covered Person is an individual included within the definition of "Target Population" and enrolled under the CHPFC.

- **Foster Care Program Contract** means the agreement between Superior HealthPlan Network("SHPN") and the State of Texas, as revised or replaced from time to time, pertaining to the provision of services by SHPN to FC Covered Persons who are beneficiaries of the State's Medicaid Comprehensive Healthcare Program for Foster Care.

- **Health Care Service Plan** means an individualized plan developed with and for FC Covered Persons with special health care needs. The Health Care Service Plan includes, but is not limited to, the following:
    - The FC Covered Person's history;
    - Summary of current medical and social needs and concerns;
    - Short and long term needs and goals;
    - A treatment plan to address the FC Covered Person's physical, psychological, and emotional health care problems and needs including a list of services required, their frequency, and a description of who will provide such services.

  The Health Care Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for FC Covered Persons in the Early Childhood Intervention ("ECI") Program.

Current Dental Terminology © American Dental Association. All Rights Reserved

- **Health Passport** means an electronic health record used to document information regarding medical services provided to an FC Covered Person.

- **HHSC** refers to the Texas Health and Human Services Commission, which is the State agency responsible for the administration of the CHPFC.

- **Medicaid Comprehensive Healthcare Program for Foster Care** (or "CHPFC") is the statewide program designed to provide comprehensive medical and behavioral health Medicaid services to members of the Target Population through a managed care provider network.

- **Medical Consenter** means the person who may consent to medical care for the FC Covered Person under Chapter 266 of the Texas Family Code.

- **Medically Necessary** means non-behavioral health related Health care services that are:
    - Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of an FC Covered Person, or endanger life;
    - Provided at appropriate facilities and at the appropriate levels of care for the treatment of an FC Covered Person's health conditions;
    - Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
    - Consistent with the diagnoses of the conditions;
    - No more intrusive or restrictive than necessary to provide a proper balance of safety; effectiveness, and efficiency;
    - Are not experimental or investigative; and
    - Are not primarily for the convenience of the FC Covered Person or Provider; and Behavioral health services that are:
        - Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
        - In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
        - Furnished in the most appropriate and least restrictive setting in which services can be safely provided;
        - The most appropriate level or supply of service that can safely be provided;
        - Could not be omitted without adversely affecting the FC Covered Person's mental and/or physical health or the quality of care rendered;
        - Not experimental or investigative; and
        - Not primarily for the convenience of the FC Covered Person or Provider.

- **Primary Care Provider** (or "PCP") means a physician or provider who has agreed with the DentaQuest to provider a medical home to Foster Care Covered Persons and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

- **Service Manager(s)** perform the functions of Service Management.

- **State Medicaid Agency** means the State agency which administers the State Medicaid managed care program, as implemented from time to time.

- **Substitute Care** means the placement of a child or young adult who is in the conservatorship of DFPS in care outside the child's or young adult's home. The term includes foster care, institutional care, adoption or placement with a relative of the child or young adult.

- **Target Population** means children and young adults in Substitute Care and/or one of the following categories: (1) DFPS conservatorship, (2) emancipated minors and young adults age 18-22 who voluntarily agree to continue in a foster care placement, or (3) young adults age 18 through the month of their 21st birthday who are participating in the MTFCY Program, and (4) young adults age 21 through the month of their 23rd birthday who are participating in the FFCHE Program.

- **Texas Health Steps** is the name adopted by the state of Texas for the federally mandated EPSDT program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. §1396d(r) and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25T.A.C., Chapter 33 (relating to EPSDT).

Current Dental Terminology © American Dental Association. All Rights Reserved

Appendix E

Non-Covered Service Disclosure Form

The Member may purchase additional services as a non-covered procedure/s or treatment/s for an additional charge. DentaQuest requires that you (the provider) and the member complete the Non- Covered Services Disclosure Form prior to rendering these services. A copy of this form must be kept in the Member's treatment record. If the Member elects to receive the non-covered procedure/s or treatment/s the member would pay a fee not to exceed the maximum rate of your usual and customary fees as payment in full for the agreed procedure/s or treatment/s.

The Member is financially responsible for such services. If the Member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the Member's treatment record. Failure to comply with this procedure will subject the provider to sanctions up to and including termination.

This section to be completed by dentist rendering care

I am recommending that _____ receive
(Member Name and Medicaid Number)
services that are not covered by the DentaQuest Covered Benefits and Fee Schedule. The following procedure codes are recommended: FEES NOT TO EXCEED PROVIDER'S UCF (usual and customary fee).

Code	Description	Fee

The total amount for service(s) to be rendered is $_____.

_____
Dentist's Signature Date

This section to be completed by member

I _____, have been told that I require
(Print Name)
services or have requested services that are not covered by the DentaQuest Covered Benefits and Fee Schedule.

Read the following statements and check either Yes or No:

Question	Yes	No
My dentist has assured me that there are no other covered benefits.		
I am willing to receive services not covered by DentaQuest.		
I am aware that I am financially responsible for paying for these services.		
I am aware that DentaQuest is not paying for these services.		

I agree to pay $_____ per month. If I fail to make this payment, I may be subject to collection action by the dentist.

Parent or Guardian Signature Date

Current Dental Terminology © American Dental Association. All Rights Reserved

OrthoCAD 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:**

Treatment Requested	
Code:	**Description of request:**

Current Dental Terminology © American Dental Association. All Rights Reserved

Continuation of Care Submission Form

DentaQuest

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:

Numbers of Adjustments Remaining:

Additional information required:

- **If the member is transferring from an existing Medicaid program: A copy of the original orthodontic approval.**
- **If the member is private pay or transferring from a commercial insurance program original diagnostic photos or models (or OrthoCad equivalent), radiographs (optional).**

Mail to:

DentaQuest, LLC
Attn: Continuation Of Care
P.O. Box 2906
Milwaukee, WI53201-2906

E-3

Current Dental Terminology © American Dental Association. All Rights Reserved

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

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

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g., 11=office, 22=Off Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J401, J432, J433, J434, J4300)

To reorder call 800.947.4746 or go online at adacatalog.org

Current Dental Terminology © American Dental Association. All Rights Reserved

ADA American Dental Association®
America's leading advocate for oral health

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

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the "tick-marks" printed in the margin.

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

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

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

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

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

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

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

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

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

PLACE OF TREATMENT

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

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

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

PROVIDER SPECIALTY

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

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	1223D0000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

Managed Care Orthodontia Review Policy and Procedure- Texas

Subject: Orthodontia Review Policy and Procedure
Effective Date: March 1, 2012
Date Last Revised: December 20, 2011; January 18, 2012; January 30, 2012

Purpose:

The Dental Contractors established a managed care policy and process to ensure consistent and equitable determination of orthodontic coverage for the children's Medicaid and CHIP dental services. Comprehensive medically necessary orthodontic services are a covered benefit for Texas Medicaid Members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Orthodontic services are covered for Texas CHIP Members for pre-and post-surgical cases related to cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Definitions:
Severe handicapping malocclusion is defined as an occlusion that is severely functionally compromised and is described in detail in Levels I, II, III, and IV.

Orthodontic terminology and extent of orthodontic services are based on the American Dental Association's Current Dental Terminology (CDT) definitions and explanations of the orthodontic codes utilized within this policy. The following definitions of dentition established by the CDT manual are recognized by the Children's Medicaid dental services:

Primary Dentition: Teeth developed and erupted first in order of time.
Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Policy:

The Dental Contractors recognize four orthodontic service levels for severe handicapping malocclusion, and each requires a different amount of time for treatment. These levels require different levels of skill, orthodontic procedures, and time for completion of the treatment plan.

1. Level I:

1.1. Dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework. (Presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth shall constitute the early mixed dentition.)

- Anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession, or severe enamel wear.
- Posterior crossbite with an associated midline deviation and asymmetric closure pattern.
- Dental cross bites, other than the above described shall not be eligible for treatment in Level I.

1.2. Level I orthodontic services must be completed within 12 months unless an exception is granted by DentaQuest upon approval of a prior authorization request submitted by the provider.

1.3. Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

1.4. Providers may submit the following procedure codes for Level I review:

Current Dental Terminology © American Dental Association. All Rights Reserved

Procedure Code	Description
D8010	Limited orthodontic treatment of the primary dentition.
D8020	Limited orthodontic treatment of the transitional dentition.
D8210	Removable appliance therapy
D8220	Fixed appliance therapy

1.5. Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

2. **Level II**:

2.1. Qualification for treatment at Level II requires submission of documentation to support the classification of handicapping malocclusion. FOUR of the following conditions must be clearly apparent in the supporting documentation:

A. Full cusp Class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar.
B. Full cusp Class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of mandibular molar distal buccal cusp.
C. Overbite measurement shall be in excess of 5 mm.
D. Overjet measurement shall be in excess of 8 mm.
E. More than four congenitally absent teeth, one or more of which shall include an anterior tooth/ or teeth.
F. Anterior crowding shall be in excess of 6 mm. in the mandibular arch.
G. Anterior cross bite of more than two of the four maxillary incisors.
H. Generalized spacing in both arches of greater than 6 mm. in each arch.
I. Recognition of early impacted maxillary canine or canines. Radiographs shall support the diagnosis demonstrating a severe mesial angulation of the erupting canine and the crown of the canine superimposed and crossing the image of the maxillary lateral incisor.

2.2. Level II orthodontic services must be completed within 24 months unless an exception is granted.

2.3. Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The Member is the child of a migrant farm worker
- The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

2.4. Providers must use the appropriate procedure code that is applicable for banding:

Procedure Code	**Description**
D8070	Comprehensive orthodontic treatment of the transitional dentition. (1 of D8070, D8080 or D8090 per lifetime)
D8080	Comprehensive orthodontic treatmentof the adolescent dentition. (1 of D8070, D8080 or D8090 per lifetime)
D8090	Comprehensive orthodontic treatmentof the adult dentition. (1 of D8070, D8080 or D8090 per lifetime)

2.5. Interceptive orthodontic treatment is not covered in conjunction with comprehensive orthodontic treatment. In addition, interceptive orthodontic treatment is not allowed when comprehensive orthodontic treatment is indicated unless there are extenuating circumstances.

2.6. Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

3. Additional Services:

3.1. There may be extenuating circumstances that warrant additional treatment, including but not limited to craniofacial anomalies and cleft palate. In the event that the Member requires additional treatment, the Provider may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances.
Each case will be reviewed and evaluated on a case by case basis for medical necessity. Level III and Level IV described below are the clinical criteria that must be met in order to qualify for additional services.

Current Dental Terminology © American Dental Association. All Rights Reserved

3.2. To submit for additional services, the provider must complete the following:
   A. Submit a prior authorization on a 2018, 2019, or greater ADA claim form with the appropriate code(s) being requested
   B. If the provider is requesting additional monthly adjustments, the code D8670 must be utilized
   C. Recent radiographs (x-rays) showing the progress made to current
   D. Photographs
   E. Treatment plan

4. Level III:

4.1. Dedicated to resolution of handicapping malocclusion in the adolescent or adult dentition. Qualification for treatment at Level III requires submission of documentation to support the classification of handicapping malocclusion. FOUR of the following conditions must be clearly apparent in the supporting documentation:
   A. Full cusp Class II molar malocclusion as described in Level II.
   B. Full cusp Class III molar malocclusion as described in Level II.
   C. Anterior tooth impaction; unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth which may be malposed but has erupted into the oral cavity and is not a qualifying element.
   D. Anterior crowding shall be in excess of 6mm in the mandibular arch.
   E. Anterior open bite shall demonstrate that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement in excess of 6 mm.
   F. Posterior open bite shall demonstrate a vertical separation by a measurement in excess of 5 mm. of several posterior teeth and not be confused with the delayed natural eruption of a few teeth.
   G. Posterior cross bite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch shall qualify.
   H. Anterior cross bite shall include more than two incisors in cross bite and demonstrate gingival inflammation, gingival recession, or severe enamel wear.
   I. Over bite shall be in excess of 5 mm.
   J. Overjet shall be in excess of 8mm.

4.2. Level III orthodontic services must be completed within 36 months unless an exception is granted.

4.3. Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:
   - The Member is the child of a migrant farm worker
   - The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

5. Level IV:

5.1. Dedicated to resolution of handicapping malocclusion in the adult dentition; complete eruption of the permanent dentition.

5.2. Qualification for treatment at level IV requires submission of documentation to support the classification of handicapping malocclusion. Documentation shall be submitted by an Oral Surgeon justifying the medical necessity of a surgical approach to treatment.
   - Non-functional Class II malocclusion
   - Non-functional Class III malocclusion

5.3. Models, panorex, Cephalogram, and photos shall be submitted with the above requested documentation for review. The correction of the malocclusion shall be beyond that of orthodontics alone and shall require pre-orthodontic and post-orthodontic procedures in conjunction with orthognathic surgery. The patient's medical needs shall be based on function and not esthetics.

5.4. Level IV orthodontic services must be completed within 48 months unless an exception is granted.

5.5. Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:
   - The Member is the child of a migrant farm worker
   - The Member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

6. Other Orthodontic Services:

6.1. The following procedure codes are used to bill for other orthodontic services:

Procedure Code	Description
D8670	Periodic orthodontic treatment visit - the number of monthly adjustments will vary based on which level was approved.

Current Dental Terminology © American Dental Association. All Rights Reserved

D8680	Debanding- Orthodontic retention (removal of appliances, construction and placement of retainers).

7. Provider Requirements:

7.1. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of Dentist.

7.2. Dentists (DDS, DMD) who want to provide any of the four levels of orthodontic services addressed in this policy must be enrolled as a dentist or orthodontist in THSteps and must have the qualifications listed below for the relevant level of service:

Level of Orthodontic Service	Qualifications
Level I or II	Completion of pediatric dental residency; or a minimum of 200 hours of continuing dental education in orthodontics.
Level I, II, III, or IV	Dentists who are orthodontic board certified or orthodontic board eligible.

7.3. Provider Type 90 – Orthodontist: Board eligible or board certified by an ADA recognized orthodontic specialty board. This provider type is eligible to provide Level I-IV.

7.4. Provider Type 48 – Texas Health Steps – Dental: In order to perform and be reimbursed for Level I and II, provider must attest to either:

A. Completion of pediatric specialty residency.
B. Minimum of 200 hours of continuing dental education in orthodontics within the last ten years.

8. **Orthodontic Prior Authorization Requirements:**

8.1. The following documentation must be submitted with the request for prior authorization:

A. ADA 2018, 2019, or newer claim form with service codes noted
B. Duplicate diagnostic models or a complete set of diagnostic photographs
C. Radiographs (x-rays)
D. Cephalometric x-ray with tracings
E. Photographs (if plaster models are submitted)
F. Treatment plan
G. **For CHIP Members Only** – a copy of the medical prior authorization approval letter for surgery

9. Completion of Comprehensive Orthodontic Services:

9.1. Prior authorization is required for completion of services (last payment) and must be reviewed for proof of completion of case.

9.2. The following documentation must be submitted with the request for prior authorization:

A. Post treatment panorex film
B. Photographs
C. A signed statement from the treating Provider indicating that treatment is complete

9.3. Providers must use the following procedure code for debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s))

10. Transfer of Comprehensive Orthodontic Services:

10.1. Prior authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the treatment initiated by the original provider.

10.2. The new provider must obtain his/her own records. The following supporting documentation of medical necessity must be submitted with the request for transfer of services:

A. All of the documentation that is required for the original request,
B. The reason the Member left the previous provider,
C. Narrative noting the treatment status.

11. Continuation of Orthodontic Case Initiated through a Private Arrangement:

Current Dental Terminology © American Dental Association. All Rights Reserved

11.1. Continuation of a case for a Member that began treatment through a private arrangement will be considered for prior authorization if the Member began treatment prior to becoming Medicaid eligible.

11.2. Continuation of a case for a Member that began treatment through a private arrangement will not be considered for prior authorization if the Member began treatment while Medicaid eligible and will be denied.

11.3. The following information is required for consideration of payment for continuation of care cases:

- A completed Orthodontic Continuation of Care Form
- A completed 2018, 2019, or greater ADA claim form listing the services to be rendered
- A copy of the Member's prior approval including the total approved case fee and payment structure
- Detailed payment history

11.4. If the Member is private pay, fee for service or transferring from a commercial insurance and now is Medicaid or CHIP eligible; the following information is required:

- A completed Orthodontic Continuation of Care Form
- A completed 2018, 2019, or greater ADA claim form listing the services to be rendered
- A copy of the Member's prior approval including the total approved case fee and payment structure
- Detailed payment history
- A copy of the original study models prior to the patient being banded
- Panorex film

12. **Orthodontic Services authorized by TMHP prior to March 1, 2012:**

12.1. The Dental Contractor has the option to re-review any and/or all orthodontic cases authorized by TMHP prior to March 1, 2012 for medical necessity.

12.2. The following information is required for review and consideration of payment for continuation of care:

- A completed Orthodontic Continuation of Care Form
- A completed 2018, 2019, or greater ADA claim form listing the services to be rendered
- A copy of the Member's prior approval including the total approved case fee and payment structure
- Detailed payment history
- A copy of the original study models prior to the patient being banded (only if requested)
- Panorex film (only if requested)

12.3. The clinical criteria used in making the qualifying decision will be the criteria stated in this document (Level I, II, III and IV).

12.4. Should the request for continuation of payment be denied due to lack of medical necessity under the new clinical criteria; the Dental Contractor will authorize a treatment plan to deband the Member.

13. Premature Termination of Comprehensive Orthodontic Services:

13.1. Premature termination of comprehensive orthodontic treatment by the originally treating provider is included in the comprehensive services

13.2. Premature termination of orthodontic services includes all of the following:

- Removal of brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers

13.3. Premature removal of an orthodontic appliance must be prior authorized. A release form must be signed by the parent or legal guardian, or by the Member if he/she is 18 years of age or older or an emancipated minor. A copy of the signed release form and a completed prior authorization request form must be submitted, and one of the following must be documented on the prior authorization request:

A. The Member is uncooperative or is non-compliant
B. The Member requested the removal of the orthodontic appliance(s)
C. The Member has requested the removal due to extenuating circumstances to include, but not limited to:
    1. Incarceration
    2. Mental health complications with a recommendation from the treating physician
    3. Foster Care placement
    4. Child of a Migrant Farm Worker, with the intent to complete treatment at a later date if Medicaid eligibility for orthodontic services continues

NOTE: A Member for whom removal of an appliance has been authorized due to the above, will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while Medicaid eligible. Should the Member choose to have the appliances removed for reasons other than those listed under "C", the Member may not be eligible for any additional Medicaid orthodontic services.

13.4. The requesting provider is responsible for removal of the orthodontic appliances, final records and x-rays at the time of termination.

13.5. Providers must use the following procedure code for premature debanding:

13.6.

Procedure Code	Description

Current Dental Terminology © American Dental Association. All Rights Reserved

D8680	Orthodontic Retention (removalof appliances, construction and placement of retainer(s))

14. Reimbursement:

14.1. An initial payment is payable when bands are placed. Providers must bill with the appropriate prior authorized procedure code.

14.2. Providers must bill the appropriate monthly adjustment code (D8670). The total number of monthly adjustments allowed will vary by level.

14.3. The last payment is payable when the treatment is complete. Providers must bill with the appropriate prior authorized procedure code (D8680).

15. **General Information:**

15.1. Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity. For example, debanding in regular treatment would limit retainers and appliance removal to a single episode however in the case of cleft palate, craniofacial and head trauma with dental consequences; the case may involve multiple courses of treatment and would gain additional consideration based on the circumstances.

15.2. Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

15.3. Members enrolled in the Dental Contractor's plan for at least one month and are receiving orthodontic treatment and either ages out or loses eligibility; the Dental Contractor is responsible for completion of payment for the course of treatment. The only exception is if the Member is disenrolled with cause but is still Medicaid eligible.

15.4. There will be no payment for denied cases.

15.5. Payment for banding includes the initial work up.

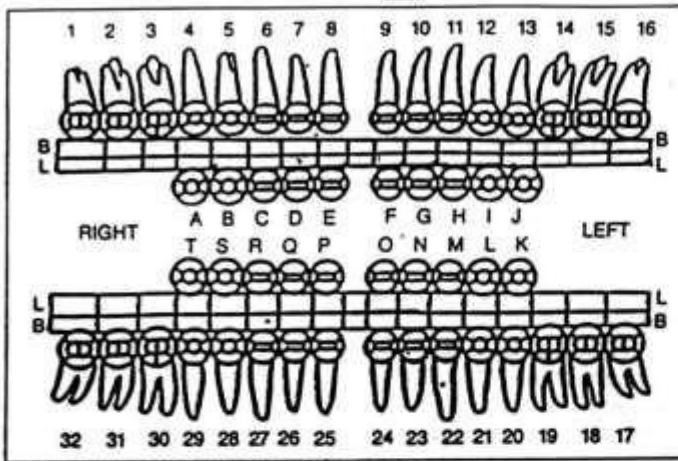
15.6. Study models submitted with the request will not be returned to the provider unless a self-addressed postage paid box is included.

Current Dental Terminology © American Dental Association. All Rights Reserved

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last First Middle



GINGIVA
MOBILITY
PROTHESIS EVALUATION
OCCLUSION 1 11 111
PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

RECALL EXAMINATION

PATIENT'S NAME _

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

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

RADIOGRAPHS	B/P	RDH/DDS

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

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

COMMENTS: _____

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

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

Authorization for Dental Treatment

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

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

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

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

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

Procedure(s): _____

Tooth Number(s): _____

Date:_____

Dentist:_____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

MEDICAL AND DENTAL HISTORY

Patient Name:_____ Date of Birth:_____

Address:_____

Why are you here today?_____

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

If yes, what type and where?_____

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

Medical Doctor's Name:_____

Address:_____

Telephone:_____

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

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

If yes, please list medications:_____

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

If yes, please list _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? Yes No

Do your ankles swell during the day? Yes No

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you ever wake up from sleep and feel short of breath? Yes No

Are you on a special diet? Yes No

Has your medical doctor ever said you have cancer or a tumor? Yes No
If Yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? Yes No
If Yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? Yes No

Do you have or have you had any disease, or condition not listed? Yes No
If yes, please list: _____

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

Indicate which of the following your have had, or have at present. Circle “Yes” or “No” for each item.

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

For Women Only:

Are you pregnant? ∆ Yes ∆ No

If yes, what month? _____

Are you nursing? ∆ Yes ∆No

Are you taking birth control pills? ∆ Yes ∆ No

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

Patient Signature:_____Date: _____

Dentist’s Signature: _ Date: _

Review Date	Changes in Health Status	Patient’s signature	Dentist’s signature

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

Current Dental Terminology © American Dental Association. All Rights Reserved

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS
DISBURSED BY DENTAQUEST USA-TX HHSC Dental Services Program

INSTRUCTIONS

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

MAINTENANCE TYPE:

_____Add
_____Change (Existing Set Up)
_____Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type: _____Checking

_____Personal _____Business (choose one)

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

Bank Name: _____

Account Holder Name: _____

Effective StartDate: _____

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

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

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

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

_____ _____
Date Print Name

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

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

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

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

APPENDIX F

Covered Benefits (See Exhibit)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for:

- STAR Health (Foster Care) –Exhibit A

Providers with benefit questions should contact DentaQuest's Customer Service department directly at: 844.776.8740, press option 2.

Dental offices are not allowed to charge Members for missed appointments. Program 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 and. 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 Avenue
Chicago, IL 60611
800.947.4746

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

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

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

Feb 1, 2024
Current Dental Terminology © American Dental Association. All Rights Reserved

DentaQuest Authorization Process

IMPORTANT

For procedures where “Authorization Required” fields indicate “**yes**”.

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

When documentation is requested:

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

When documentation is requested “with claim:”

“Authorization Required” Field	“Documentation Required” Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested with Claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

Current Dental Terminology © American Dental Association. All Rights Reserved

Exhibit A Benefits Covered for STAR Health (Foster Care)
Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health. A First Dental Home visit (D0145) is only allowed for Providers (General and Pediatric Dentists) that have received training and certification by DSHS before reimbursement can occur. Training information may be found by going to: http://www.txhealthsteps.com/cms/. D0145 is limited to 1 per day with a maximum of 10 allowed per member's lifetime with at least 60 days between dates of service per provider. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping withthe federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations. All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid. Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Box 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations. One of (D0120) per 6 Month(s) Per Provider. One of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Day(s) Per patient. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement for exam. One of (D0150) per 36 Month(s) Per Provider. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement for exam. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-23		No	Limited to one every six months by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0140	limited oral evaluation-problem focused	0-23		No	Limited to one service per day by the same provider OR location or two services per day per patient by different providers. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with routine dental services. Document of Medical Necessity must be indicated on the claim.	narrative of medical necessity

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0145	first dental home oral evaluation	6-35 months		No	Providers must be certified by Texas Health Steps staff to perform this procedure as a First Dental Home (FDH) Provider. Members are limited to one D0145 per day with a maximum of 10 services allowed per member's lifetime with at least 60 days between dates of service per provider. Cannot be billed within a 6-month period of a (D0120 or D0150). Codes D1330, D1206, D1120, and D1208 will be denied when billed on the same date of service as a D0145. D0145 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0150	comprehensive oral evaluation - new or established patient	0-23		No	Limited to one service every three years by the same provider or location. Denied when submitted for the same DOS as D0145 by any provider. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location. Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0160	detailed and extensive oral eval-problem focused, by report	1 - 23		No	Limited to one service per day by the same provider OR location. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity
D0170	re-evaluation, limited problem focused	0-23		No	Limited to one service per day by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	13 - 23		No	Limited to one service per day by the same provider OR location. Denied when submitted for the same DOS as procedure codes D0120, D0140, D0145, D0150, D0160, D0170, D0180 by the same provider.	narrative of medical necessity
D0210	intraoral - complete series of radiographic images	2-5		Yes	Limited to one service of D0210 or D0330 everythree years by the same provider OR location. Narrative of medical necessity and x-ray.	narr. of med. necessity, pre-op x-ray(s)
D0210	intraoral - complete series of radiographic images	6 – 23		No	Limited to one service of D0210 or D0330 everythree years by the same provider OR location.	
D0220	intraoral - periapical first radiographic image	1 – 23		No	Limited to one service per day by the same provider OR location.	
D0230	intraoral - periapical each additional radiographic image	1 – 23		No		
D0240	intraoral - occlusal radiographic image	0-23		No	Limited to two services per day by the same provider OR location.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	1 – 23		No	Limited to one service per day by the same provider OR location.	
D0270	bitewing - single radiographic image	1		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. Narrative of medical necessity and x-ray showing fully erupted primary first molar.	narr. of med. necessity, pre-op x-ray(s)

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	2-23		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location.	
D0272	bitewings - two radiographic images	1		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. Narrative of medical necessity and x-ray showing fully erupted primary first molar.	narr. of med. necessity, pre-op x-ray(s)
D0272	bitewings - two radiographic images	2-23		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0273	bitewings - three radiographic images	1-9		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient. Narrative of medical necessity and x-rays showing fully erupted left and right second permanent molars.	narr. of med. necessity, pre-op x-ray(s)
D0273	bitewings - three radiographic images	10 - 23		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0274	bitewings - four radiographic images	1-9		Yes	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient. Narrative of medical necessity and x-rays showing fully erupted left and right second permanent molars.	narr. of med. necessity, pre-op x-ray(s)

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	10 – 23		No	Limited to one service of D0270, D0272, D0273, D0274 per day by the same provider OR location. One service of D0210, D0272 per day per patient.	
D0277	vertical bitewings - 7 to 8 films	2 – 23		No	Limited to one service per day by the same provider OR location. One service of D0210, D0277 per day per patient.	
D0310	sialography	1 – 23		No		
D0320	temporomandibular joint arthrogram, including injection	1 – 23		No		
D0321	other temporomandibular joint films, by report	1 – 23		No		
D0322	tomographic survey	1 – 23		No		
D0330	panoramic radiographic image	3-5		Yes	Limited to one service of D0210 or D0330 every three years by the same provider OR location. One service of D0210, D0277, D0330 per day per provider. Narrative of medical necessity and x-ray.	narr. of med. necessity, pre-op x-ray(s)
D0330	panoramic radiographic image	6 - 23		No	Limited to one service of D0210 or D0330 every three years by the same provider OR location. One service of D0210, D0277, D0330 per day per provider.	
D0340	cephalometric radiographic image	1 - 23		No	Limited to one service per day by the same provider OR location. Not billable with orthodontic work up.	

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-23		No	Limited to one service per day by the same provider OR location. Not billable with orthodontic work up.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-23		Yes	Limited to a combined maximum of three services per year, per patient.	narrative of medical necessity
D0415	bacteriologic studies	1 - 23		No		
D0460	pulp vitality tests	1 - 23		No	Limited to one service per day by the same provider OR location. Not allowed on primary teeth. Not billable with endodontic procedures.	
D0470	diagnostic casts	1 - 23		No	Not billable with crowns, prosthodontics (fixed or removable) orthodontics, or diagnostic work up.	
D0502	other oral pathology procedures, by report	1 - 23		No		
D0601	Caries risk assessment and documentation, with a finding of low risk	0-23		No	Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0-23		No	Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	
D0603	Caries risk assessment and documentation, with a finding of high risk	0-23		No	Codes D0120, D0145, and D0150 must be performed on same date as D0601, D0602, or D0603 to receive reimbursement.	

Clinical Oral Evaluations/Diagnostics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D0999	unspecified diagnostic procedure, by report	1 - 23		Yes		narrative of medical necessity

Exhibit A Benefits Covered for STAR Health (Foster Care)
Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Box 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances

Preventative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 23		No	Limited to one D1110, D1120 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. Denied when billed with emergency treatment. Cannot be billed by Orthodontist or Maxillofacial Surgery Specialist.	
D1120	prophylaxis - child	0-12		No	Limited to one D1110, D1120 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. Denied when billed with emergency treatment. Cannot be billed by Orthodontist or Maxillofacial Surgery Specialist.	
D1206	topical application of fluoride varnish	0-23		No	One service of D1206, D1208 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. If submitted on emergency claim, D1206 will be denied. Cannot be billed by Orthodontist or Maxillofacial Surgery Specialist. Includes oral health instructions.	

D1208	topical application of fluoride - excluding varnish	0-23		No	One service of D1206, D1208 per patient, any provider, per six-month period. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. If submitted on emergency claim, D1206 will be denied. Cannot be billed by Orthodontist or Maxillofacial Surgery Specialist. Includes oral health instructions.	
D1330	oral hygiene instructions	0-23		No	One service of D1330 per year, per patient, any provider. Denied when billed for the same DOS as oral hygiene instructions (D1330), prophylaxis (D1110 or D1120), or topical fluoride treatments (D1206 or D1208), by any provider. Limited to services performed in an office setting.	
D1351	sealant - per tooth	1-5	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. For those members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 6-14 age band. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	Narrative of medical necessity
D1351	sealant - per tooth	17-23	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. For those members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 6-14 age band. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	

D1351	sealant - per tooth	1-23	Teeth 1, 6 - 11, 16, 17, 22 - 27, 32, 51 - 82, C - H, M - R, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. For those members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 6-14 age band. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	Narrative of medical necessity and photos
D1351	sealant - per tooth	1-5	Teeth A, B, I - L, S, T	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	
D1351	sealant - per tooth	15-16	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	Narrative of medical necessity
D1351	sealant - per tooth	7-14	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	
D1351	sealant - per tooth	7-23	Teeth A, B, I - L, S, T	No	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	

D1351	sealant - per tooth	6 (72nd month – 83rd month)	Teeth 2 - 5, 12 - 15, 18 - 21, 28 – 31, A, B, I - L, S, T	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1351 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. If submitted on emergency claim, D1351 will be denied. Not billable by Orthodontist or Oral Surgeon.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.	5-6	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1352 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.	7-14	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1352 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.	5-23	Teeth 1, 16, 17, 32	Yes	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1352 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. For members without a history of caries or restorations within the past year, such narrative should describe the tooth anatomy of the area to be sealed to support that the tooth is at risk for dental caries and the affectivity of placing a sealant outside of the 5-14 age band. Documentation can also include patient-centric risk factors that may exist. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider within 180 days prior.	Narrative of medical necessity and photos

D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.	15-23	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Y	Limited to one service of (D1351, D1352) per tooth, per lifetime. D1352 will be denied when submitted for the same date of service as any D4000 Series periodontal procedure code. Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior.	Narrative of medical necessity
D1354	interim caries arresting medicament application – per tooth	6 months-6 years	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	D1354 is limited to one applications, per lifetime of tooth, with 30 days minimum separation between application dates. Not allowed on the same date of service as D1351 or D1352 on the same tooth. D1354 must be deemed medically necessary by Main Dental Home provider. Silver Diamine Fluoride is the only materials that may be used for D1354.	
D1510	space maintainer-fixed-unilateral – Per Quadrant	1 - 6	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant. After premature loss of a deciduous/primary first and/or second molar for clients who are 1 through 12 years of age (procedure codes D1510 and D1516 and D1517)	
D1510	space maintainer-fixed-unilateral – Per Quadrant	7 - 12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant. After premature loss of a deciduous/primary first and/or second molar for clients who are 1 through 12 years of age (procedure codes D1510 and D1516 and D1517)	
D1516	space maintainer – fixed – bilateral, maxillary	1 - 6	Per Arch (01, UA)	Yes	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch. After premature loss of a deciduous/primary first and/or second molar (TID A, B, I, and J) for clients who are 1 through 12 years of age (procedure codes D1510 and D1516)	

D1516	space maintainer – fixed – bilateral, maxillary	7 - 12	Per Arch (01, UA)	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch. After premature loss of a deciduous/primary first and/or second molar (TID A, B, I, and J) for clients who are 1 through 12 years of age (procedure codes D1510 and D1516)	
D1517	space maintainer – fixed – bilateral, mandibular	1 - 6	Per Arch (02, LA)	Yes	One of (D1517, D1527) per 24 Month(s) Per patient, per lifetime, same arch. After premature loss of a deciduous/primary first and/or second molar (TID K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517)	
D1517	space maintainer – fixed – bilateral, mandibular	7 - 12	Per Arch (02, LA)	No	One of (D1517, D1527) per 24 Month(s) Per patient, per lifetime, same arch. After premature loss of a deciduous/primary first and/or second molar (TID K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517)	
D1520	Space maintainer-removable-unilateral	1 - 6	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D1510 or D1520) per lifetime, per patient, per quadrant.	
D1520	Space maintainer-removable-unilateral	7 - 12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limit to one service of (D1510 or D1520) per lifetime, per patient, per quadrant.	
D1526	space maintainer – removable – bilateral, maxillary	1 - 6	Per Arch (01, UA)	Yes	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch. After premature loss of a deciduous/primary first and/or second molar (TID A, B, I, and J) for clients who are 1 through 12 years of age (procedure codes D1510 and D1516)	

D1526	space maintainer – removable – bilateral, maxillary	7 - 12	Per Arch (01, UA)	No	Limit to one service of (D1516, D1526) per lifetime, per patient, arch. After premature loss of a deciduous/primary first and/or second molar (TID A, B, I, and J) for clients who are 1 through 12 years of age	
D1527	space maintainer – removable – bilateral, mandibular	1 - 6	Per Arch (02, LA)	Yes	Limit to one service of (D1517 or D1527) per lifetime, per patient, per arch. After premature loss of a deciduous/primary first and/or second molar (TID K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517). Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1527	space maintainer – removable – bilateral, mandibular	7 - 12	Per Arch (02, LA)	No	Limit to one service of (D1517 or D1527) per lifetime, per patient, per arch. After premature loss of a deciduous/primary first and/or second molar (TID K, L, S, and T) for clients who are 1 through 12 years of age (procedure codes D1510 and D1517). Removal of a fixed space maintainer is not payable to the provider or provider group that originally placed the device.	
D1551	re-cement or re-bond bilateral space maintainer - maxillary	1 - 6	Per Arch (01, UA)	Yes	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1551	re-cement or re-bond bilateral space maintainer - maxillary	7 - 12	Per Arch (01, UA)	No	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	

D1552	re-cement or re-bond bilateral space maintainer - mandibular	1 - 6	Per Arch (02, LA)	Yes	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1552	re-cement or re-bond bilateral space maintainer - mandibular	7 - 12	Per Arch (02, LA)	No	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	1 - 6	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	7 - 12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed within 12 months of initial placement. The recementation of space maintainers (procedure code D1551, D1552, or D1553) may be considered for reimbursement to either the same or different Texas Health Steps dental provider when procedure code D1510, D1516, or D1517 has been previously reimbursed.	
D1556	removal of fixed unilateral space maintainer - per quadrant	1 - 6	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	

D1556	removal of fixed unilateral space maintainer - per quadrant	7 - 12	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1557	removal of fixed bilateral space maintainer - maxillary	1 - 6	Per Arch (01, UA)	Yes	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1557	removal of fixed bilateral space maintainer - maxillary	7 - 12	Per Arch (01, UA)	No	Not allowed by same provider OR location that placed appliance. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1558	removal of fixed bilateral space maintainer - mandibular	1 - 6	Per Arch (02, LA)	Yes	Not allowed by same provider OR location that placed appliance. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1558	removal of fixed bilateral space maintainer - mandibular	7 - 12	Per Arch (02, LA)	No	Not allowed by same provider OR location that placed appliance. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device.	
D1575	distal shoe space maintainer – fixed - unilateral	3 - 6	Teeth A, J, K, T	Yes	Limit to one service of (D1575) per lifetime, per patient, per tooth.	

D1575	distal shoe space maintainer – fixed - unilateral	84th month through the 95th month birthday	Teeth A, J, K, T	No	Limit to one service of (D1575) per lifetime, per patient, per tooth.	

Exhibit A Benefits Covered for STAR Health (Foster Care)

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. 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. 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.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

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

Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form.

When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM.

The following codes require prior authorization for all ages: D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792, and D2794.

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

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-23	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	0-23	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2160	amalgam - three surfaces, primary or permanent	1 - 23	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	1 - 23	Teeth 1 - 32, A - T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2330	resin-based composite - one surface, anterior	0-23	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2331	resin-based composite – two surfaces, anterior	0-23	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2332	resin-based composite - three surfaces, anterior	1 - 23	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 - 23	Teeth C - H, M - R	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934. D2335 and D2390 when provided to primary teeth are limited to once per lifetime, per tooth, any provider.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 - 23	Teeth 6 - 11, 22 - 27	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934.	
D2390	resin-based composite crown, anterior	0-23	Teeth C - H, M - R	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934. D2335 and D2390 when provided to primary teeth are limited to once per lifetime, per tooth, any provider.	
D2390	resin-based composite crown, anterior	0-23	Teeth 6 - 11, 22 - 27	No	D2335 and D2390 will deny if any of the following restorations have been paid on the same tooth within last 12 months: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, and D2390, D2930, D2931, D2932, D2933, and D2934.	
D2391	resin-based composite - one surface, posterior	0-23	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	0-23	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2393	resin-based composite - three surfaces, posterior	1 - 23	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2394	resin-based composite - four or more surfaces, posterior	1 - 23	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Limit to one service of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394), per year, per provider, per tooth.	
D2510	inlay - metallic -1 surface	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2520	inlay-metallic-2 surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2530	inlay-metallic-3+ surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2542	onlay - metallic - two surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2543	onlay-metallic-3 surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2544	onlay-metallic-4+ surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2650	inlay-composite/resin 1surface	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2651	inlay-composite/resin-2 surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2652	inlay-composite/resin-3+ surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2662	onlay-composite/resin-2 surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2663	onlay-composite/resin-3 surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2664	onlay-composite/resin-4+ surfaces	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2710	crown - resin-based composite (indirect)	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2720	crown-resin with high noble metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2721	crown - resin with predominantly base metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2722	crown - resin with noble metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2740	crown - porcelain/ceramic	13 - 23	Teeth 4-13, 20-29	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2750	crown - porcelain fused to high noble metal	13 - 23	Teeth 4-13, 20-29	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	13 - 23	Teeth 4-13, 20-29	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2752	crown - porcelain fused to noble metal	13 - 23	Teeth 4-13, 20-29	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2780	crown - ¾ cast high noble metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2781	crown - ¾ cast predominantly base metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2782	crown - ¾ cast noble metal	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2783	crown - ¾ porcelain/ceramic	13 - 23	Teeth 6 - 11, 22 - 27	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2790	crown - full cast high noble metal	13 - 23	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2791	crown - full cast predominantly base metal	13 - 23	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2792	crown - full cast noble metal	13 - 23	Teeth 1–5, 12–21, 28–32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2794	crown – titanium and titanium alloys	13 - 23	Teeth 1 - 32	Yes	Limit to one service of (D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	13 - 23	Teeth 1 - 32	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	4 - 23	Teeth 1 - 32	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2920	re-cement or re-bond crown	1 - 23	Teeth 1 - 32, A - T	No	Limit to one service every six months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2930	prefabricated stainless steel crown - primary tooth	0-23	Teeth A - T	No	Limit to one service per lifetime, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2931	prefabricated stainless steel crown-permanent tooth	1 - 23	Teeth 1 -32	No	D2931 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, or D2932.	

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2932	prefabricated resin crown	1 - 23	Teeth 1-32, C-H, M-R	No	D2932 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, or D2932.	
D2933	prefabricated stainless steel crown with resin window	0-23	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2934	prefabricated esthetic coated stainless steel crown – primary tooth	0-23	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2940	protective restoration	0-23	Teeth 1 - 32, A - T	No	Not allowed with any other D2000, D3000, or D6000 series code, but is allowed with D3110 and D3120.	
D2950	core buildup, including any pins when required	4 - 23	Teeth 1 - 32	No	Limited to one service of D2950 per year, per patient, per tooth. Limit to one service of (D2950, D2952, D2954) per day, per patient, per tooth. Not allowed on primary teeth.	
D2951	pin retention - per tooth, in addition to restoration	4 - 23	Teeth 1 - 32	No	Limited to one service every five years, per patient, per tooth. Not allowed on primary teeth.	
D2952	cast post and core in addition to crown	13 - 23	Teeth 1 - 32	No	Limited to one service every five years, per patient, per tooth. Not allowed on primary teeth. Not payable with D2950.	

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2953	each additional cast post – same tooth	13 - 23	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2952.	
D2954	prefabricated post and core in addition to crown	13 - 23	Teeth 1 - 32	No	Limited to one service of (D2952, D3950) per day, per patient, per tooth. Not allowed on primary teeth.	
D2955	post removal (not in conjunction with endodontic therapy)	4 - 23	Teeth 1 - 32	No	Limited to one service of (D3346, D3347, D3348) per day, per patient, per tooth. Not allowed on primary teeth.	
D2957	each additional prefabricated post - same tooth	13 - 23	Teeth 1 - 32	No	Not allowed on primary teeth. Must be billed with D2954.	
D2960	labial veneer (laminate)-chair	13 - 23	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2961	labial veneer (resin laminate) - laboratory	13 - 23	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2962	labial veneer (porc laminate) - laboratory	13 - 23	Teeth 1 - 32	Yes	Limited to one service of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) every ten years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D2971	additional procedures to construct new crown under partial denture framework	13 - 23	Teeth 1 - 32	Yes	Limited to four services per Lifetime, Per patient, per tooth. Allowed only to the same provider that performed the cementation in conjunction with the crown.	narrative of medical necessity

Restorative						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D2980	crown repair, by report	1 - 23	Teeth 1 - 32	No		
D2999	unspecified restorative procedure, by report	1 - 23	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
Payment for conventional root canal treatment is limited to treatment of permanent teeth. The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet 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 any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered. Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development. The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included. Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Box 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (excluding final restoration)	1 - 23	Teeth 1 - 32	No	(D3110) may be reimbursed for the same tooth, on the same date of service, by the same provider or location when billed with D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2510, D2520, D2530, D2542, D2543, D2544, D2650, D2651, D2652, D2662, D2663, D2664, D2410, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2931, D2932.	
D3120	pulp cap - indirect (excluding final restoration)	1 - 23	Teeth 1 - 32	No	(D3120) will only be reimbursed when submitted with D2940 for the same TID, on the same date of service, by the same provider or location. Any indirect pulp caps placed with routine restorations are considered inclusive of the final restoration and are not separately reimbursable.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-23	Teeth 2 - 15, 18 - 31	No	Limited to one service of (D3220, D3230, D3240, D3310, D3320, D3330) per six months, per patient, per tooth.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-23	Teeth A - T	No	One service of (D3220, D3230, D3240, D3310, D3320, D3330) per lifetime, per patient, per tooth for primary Teeth.	

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 - 23	Teeth C - H, M - R	No	Limit to one service per lifetime, per patient, per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 - 23	Teeth A, B, I - L, S, T	No	Limit to one service per lifetime, per patient, per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6 - 23	Teeth 6 - 11, 22 - 27	No	Limit to one service per lifetime, per patient, per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	6 - 23	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Limit to one service per lifetime, per patient, per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	6 - 23	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Limit to one service per lifetime, per patient, per tooth.	
D3346	retreatment of previous root canal therapy-anterior	6 - 23	Teeth 6 - 11, 22 - 27	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	6 - 23	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	Limit to one service per lifetime, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D3348	retreatment of previous root canal therapy-molar	6 - 23	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	Limit to one service per lifetime, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3351	apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	6 - 23	Teeth 1 - 32	No		
D3352	apexification/recalcification – interim medication replacement	6 - 23	Teeth 1 - 32	No		
D3353	apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	6 - 23	Teeth 1 - 32	No		
D3410	apicoectomy - anterior	6 - 23	Teeth 6 - 11, 22 - 27	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3421	apicoectomy - premolar (first root)	6 - 23	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3425	apicoectomy - molar (first root)	6 - 23	Teeth 1 - 3, 14 - 19, 30 - 32	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3426	apicoectomy (each additional root)	6 - 23	Teeth 1 - 5, 12 - 21, 28 - 32	Yes		narr. of med. necessity, post-op x-ray(s)

Endodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D3430	retrograde filling - per root	6 - 23	Teeth 1 - 32	No		
D3450	root amputation - per root	6 - 23	Teeth 1 - 32	No		
D3460	endodontic end osseous implant	16 - 23	Teeth 1 - 32	Yes		narr. of med. necessity, pre and post-op x-ray(s)
D3470	intentional reimplantation	6 - 23	Teeth 1 - 32	No		
D3910	surgical procedure for isolation of tooth with rubber dam	1 - 23	Teeth 1 - 32	No		
D3920	hemi section (including any root removal), not incl root canal therapy	6 - 23	Teeth 1 - 3, 14 - 19, 30 - 32	No		
D3950	canal preparation and fitting of preformed dowel or post	6 - 23	Teeth 1 - 32	No		narr. of med. necessity, post-op x-ray(s)
D3999	unspecified endodontic procedure, by report	1 - 23	Teeth 1 - 32, A - T	Yes		narr. of med. necessity, post-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
Claims for preventive dental procedure codes D1110, D1120, D1203, D1204, D1206, D1351, and D1352 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes. Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member’s file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Box 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4210, D4211) every two years, per patient, per quadrant.	narr. of med. necessity, pre and post-op x-ray(s)
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4210, D4211) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4230	anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant	13 - 23		Yes	Limit to one service of (D4230, D4231) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4231	anatomical crown exposure - one to three teeth or bounded tooth spaces per quadrant	13 - 23		Yes	Limit to one service of (D4230, D4231) every two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4240	gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4240, D4241) every two years, per patient, per quadrant.	narr of med necessity & full mouth xrays

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4241	gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4240, D4241) every two years, per patient, per quadrant.	narr of med necessity & full mouth x-rays
D4245	apically positioned flap	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service per two years, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D4249	clinical crown lengthening – hard tissue	13 - 23	Teeth 1 - 32	Yes	Limit to one service per lifetime, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4260, D4261) per year, per patient, per quadrant.	full mouth x-rays, perio charting & narrative
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit to one service of (D4260, D4261) per year, per patient, per quadrant.	full mouth x-rays, perio charting & narrative
D4266	guided tissue regenerate-resorbable barrier, per site, per tooth	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4267	guided tissue regeneration – non-resorbable barrier, per site, per tooth	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4270	pedicle soft tissue graft procedure	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4273	subepithelial connective tissue graft procedure	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4274	distal or proximal wedge procedure	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4275	soft tissue allograft	13 - 23	Teeth 1 - 32	Yes	Limit to one service per day, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4276	combined connective tissue and double pedicle graft	13 - 23	Teeth 1 - 32	Yes	Limit to one service per two years, per patient, per tooth. Not payable in addition to D4273 and D4276 for the same date of service.	narr. of med. necessity, pre-op x-ray(s)
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	13 - 23	Teeth 1 - 32, 51 - 82	Yes	Limit to one service per two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	13 - 23	Teeth 1 - 32, 51 - 82	Yes	Must be billed on the same DOS as D4277.	narr. of med. necessity, pre-op x-ray(s)
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	13 - 23	Teeth 1 - 32	Yes	Limited to three services of (D4283, D4285) per day, per provider, per tooth. D4283 is an add-on code and must be billed along with procedure code D4273.	narr. of med. necessity, pre-op x-ray(s)
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	13 - 23	Teeth 1 - 32	Yes	Limited to three services of (D4283, D4285) per day, per provider, per tooth. D4283 is an add-on code and must be billed along with procedure code D4273.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planning - four or more teeth per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	D4341 is denied if provided within 21 days of D4355. D4341 and D4342 are denied when submitted for the same DOS as other D4000 series codes, except D4341 and D4342, or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525, Any Provider.	full mouth x-rays, perio charting & narrative

Periodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planning - one to three teeth per quadrant	13 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	D4342 and D4341 are denied when submitted for the same DOS as other D4000 series codes, except D4341 and D4342, or with D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525, Any Provider.	full mouth x-rays, perio charting & narrative
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	13 - 23		Yes	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes (D4210, D4211, D4230, D4231, D4240, D4241, D4245, D4249, D4260, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4278, D4283, D4285, D4320, D4321, D4381, D4910, D4920, D4999) or with D0150, D0160, D0180, D1110, D1120, D1206, D1208, D1351, D1510, D1515, D1520, or D1525.	narr. of med. necessity, pre and post-op x-ray(s)
D4381	localized delivery of antimicrobial agents	13 - 23	Teeth 1 - 32	Yes	Limit one service every two years, per patient, per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4910	periodontal maintenance procedures	13 - 23		Yes	Limit of two services per year, per patient. Once a D4910 is used, then only a D4910 can be used. Cannot be used in conjunction with D4341 on the same date of service. Only allowed in conjunction with a history of periodontal pre-surgical or surgical treatment, excluding D4355. Limit is 2 times per year either code D1110 or D4910 but not both.	narr. of med. necessity, pre-op x-ray(s)
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	13 - 23		No		
D4999	unspecified periodontal procedure, by report	13 - 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member. Authorization for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. Authorization for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion. Dentures will not be preauthorized when: Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable. A preformed denture with teeth already mounted forming a denture module is not a covered service. BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE. Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation. Covered dental services that indicate "Yes" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Box 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Exhibit A Benefits Covered for STAR Health (Foster Care)
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the ADA claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	3 – 23	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	3 – 23	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	13 – 23	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient. One of (D5130) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	13 – 23	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient. One of (D5140) per 1 Lifetime Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	6 – 23		Yes	Limit one service of (D5211, D5213, D5864) every five years, per patient.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	6 – 23		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	9 – 23		Yes	Limit one service of (D5211, D5213, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	9 – 23		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	3 – 23		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	3 – 23		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	6 – 23		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	6 – 23		No	Limit one service per year, per patient. Not covered within 6 months of placement.	
D5511	repair broken complete denture base, mandibular	3 – 23	Per Arch (02, LA)	No	Cost of repairs cannot exceed replacement costs.	

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5512	repair broken complete denture base, maxillary	3 – 23	Per Arch (01, UA)	No	Cost of repairs cannot exceed replacement costs.	
D5520	replace missing or broken teeth - complete denture (each tooth)	3 – 23	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	
D5611	repair resin partial denture base, mandibular	3 – 23	Teeth 17 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5612	repair resin partial denture base, maxillary	3 – 23	Teeth 1 - 16	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5630	repair or replace broken clasp	6 – 23	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5640	replace broken teeth-per tooth	6 – 23	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5650	add tooth to existing partial denture	6 – 23	Teeth 1 - 32	No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.
D5660	add clasp to existing partial denture	6 – 23		No	Cost of repairs cannot exceed replacement costs.	The laboratory portion of the claim must be submitted.

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	6 – 23		No	Limit one service every three years, per patient. Not covered within 6 months of placement. Denied with D5211, D5213, D5281, D5640.	
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	6 – 23		No	Limit one service every three years, per patient. Not covered within 6 months of placement. Denied with D5211, D5213, D5281, D5640.	
D5710	rebase complete maxillary denture	4 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5710 placement not covered within 12 months of D5110, D5130, D5211, or D5213, any provider.	
D5711	rebase complete mandibular denture	4 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	
D5720	rebase maxillary partial denture	7 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5710 placement not covered within 12 months of D5110, D5130, D5211, or D5213, any provider	
D5721	rebase mandibular partial denture	7 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	
D5730	reline complete maxillary denture (chairside)	4 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5110, D5130, D5211 and D5213 not covered within 12 months of D5730 placement, any provider.	
D5731	reline complete mandibular denture (chairside)	4 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5740	reline maxillary partial denture (chairside)	7 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5710 placement not covered within 12 months of D5110, D5130, D5211, or D5213, any provider.	
D5741	reline mandibular partial denture (chairside)	7 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	
D5750	reline complete maxillary denture (laboratory)	4 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5710 placement not covered within 12 months of D5110, D5130, D5211, or D5213, any provider	
D5751	reline complete mandibular denture (laboratory)	4 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	
D5760	reline maxillary partial denture (laboratory)	7 – 23		No	Limit one service of (D5710, D5720, D5730, D5740, D5750, and D5760) every 36 months, per provider. D5710 placement not covered within 12 months of D5110, D5130, D5211, or D5213, any provider.	
D5761	reline mandibular partial denture (laboratory)	7 – 23		No	Limit one service of (D5711, D5721, D5731, D5741, D5751, and D5761) every 36 months, per provider. D5711 placement not covered within 12 months of D5120, D5140, D5212, or D5214 any provider.	
D5810	interim complete denture-maxillary	3 – 23		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5811	interim complete denture-mandibular	3 – 23		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (maxillary)	3 – 23		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5821	interim partial denture-mandibular	3 – 23		Yes	Limit to one service per lifetime, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5850	tissue conditioning, maxillary	3 – 23		No		
D5851	tissue conditioning, mandibular	3 – 23		No		
D5862	precision attachment, by report	4 – 23	Teeth 1 - 32	No		
D5863	Overdenture - complete maxillary	4 – 23	Per Arch (01, UA)	Yes	Limit one service of (D5110, D5130, D5863) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5864	Overdenture - partial maxillary	4 – 23		Yes	Limit one service of (D5211, D5213, D5864) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5865	Overdenture - complete mandibular	4 – 23	Per Arch (02, LA)	Yes	Limit one service of (D5120, D5140, D5865) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5866	unspecified removable prosthodontic procedure, by report	4 – 23		Yes	Limit one service of (D5212, D5214, D5866) every five years, per patient.	narr. of med. necessity, pre-op x-ray(s)
D5899	unspecified removable prosthodontic procedure, by report	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5911	facial moulage (sectional)	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5912	facial moulage (complete)	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5913	nasal prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5914	auricular prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5915	orbital prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5916	ocular prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5919	facial prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5922	nasal septal prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5923	ocular prosthesis, interim	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5924	cranial prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5925	facial augment implant prosthesis	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5926	nasal prosthesis, replacement	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5927	auricular prosthesis, replace	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5928	orbital prosthesis, replace	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5929	facial prosthesis, replacement	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5932	obturator prosthesis, definitive	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5933	obturator prosthesis, modification	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5934	mandibular resection prosthesis with guide flange	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5935	mandibular resection prosthesis without guide flange	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5936	obturator prosthesis, interim	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5937	trismus appliance (not for TMD treatment)	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5951	feeding aid	0-23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5952	speech aid prosthesis, pediatric	0-23		Yes		narr. of med. necessity, pre-op x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5953	speech aid prosthesis, adult	13 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5954	palatal augment prosthesis	0-23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5955	palatal lift prosthesis, definitive	0-23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5958	palatal lift prosthesis, interim	0-23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5959	palatal lift prosthesis, modification	0-23		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-23		Yes		narrative of medical necessity
D5982	surgical stent	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5983	radiation carrier	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5984	radiation shield	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5985	radiation cone locator	1 – 23		Yes		narr. of med. necessity, pre and post-op x-ray(s)
D5986	fluoride gel carrier	1 – 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Prosthodontics, removable						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D5987	commissure splint	1 - 23		Yes		narr. of med. necessity, pre-op x-ray(s)
D5988	surgical splint	1 – 23		Yes	Not allowed within 6 months of delivery.	narr. of med. necessity, pre-op x-ray(s)
D5992	Adjust maxillofacial prosthetic appliance, by report	0-23		No	Limit one service every five years, per patient.	
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-23		No		
D5999	unspecified maxillofacial prosthesis, by report	1 - 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
BILLING AND REIMBURSEMENT FOR CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETIC SHALL BE BASED UPON THE CEMENTATION DATE. Periapical radiographs are required for each tooth involved in the authorization request. The criteria used by DentaQuest is noted below: · At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease). · The space cannot be filled with a removable partial denture. · The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch). · Each abutment or each pontic constitutes a unit in a bridge. · Porcelain is allowed on all teeth. 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. Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member’s file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Box 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6211	pontic-cast base metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6212	pontic - cast noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6240	pontic-porcelain fused-high noble	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6241	pontic-porcelain fused to base metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6242	pontic-porcelain fused-noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6250	pontic-resin with high noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6251	pontic-resin with base metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6252	pontic-resin with noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6545	retainer - cast metal fixed	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6549	Resin retainer-For resin bonded fixed prosthesis	16 - 23	Teeth 1 - 32	No	Limit one service every five years, per patient.	
D6720	crown-resin with high noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6721	crown-resin with base metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6722	crown-resin with noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6740	retainer crown – porcelain/ceramic	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6750	crown-porcelain fused high noble	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6751	crown-porcelain fused to base metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6752	crown-porcelain fused noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6780	crown-3/4 cst high noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	16 - 23	Teeth 1 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6790	crown-full cast high noble	16 - 23	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6791	crown - full cast base metal	16 - 23	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)

Prosthodontics, fixed						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D6792	crown - full cast noble metal	16 - 23	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Limit one service of the following (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) every five years, per patient, per tooth.	narr. of med. necessity, pre and post-op x-ray(s)
D6920	connector bar	16 - 23	Per Arch (01, 02, LA, UA)	Yes	Limit one service every five years, per patient, per tooth.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	16 - 23		No	Not allowed within 6 months of initial placement.	
D6940	stress breaker	16 - 23	Teeth 1 - 32	No	Limit one service every five years, per patient, per tooth.	
D6950	precision attachment	16 - 23	Teeth 1 - 32	No	Limit one service every five years, per patient, per tooth.	
D6980	fixed partial denture repair	16 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D6999	fixed prosthodontic procedure	16 - 23	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
Reimbursement includes local anesthesia and routine post-operative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member’s file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Box 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-23	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-4	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-23	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5 - 23	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10 - 23	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth-soft tissue	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth-partially bony	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth-completely bony	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narr. of med. necessity, pre-op x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	1 - 23	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		
D7260	oroantral fistula closure	1 - 23	Teeth 1 - 16	Yes		narr. of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	1 - 23	Teeth 1 - 16	Yes	May not be paid for the same date of service as D7260.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	1 - 23	Teeth 1 - 32	No		
D7272	tooth transplantation (includes reimplantation from one site to another)	1 - 23	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	1 - 23	Teeth 2-15, 18-31	Yes	D7280 will be denied unless billed with an authorized procedure code D7283, for the same tooth, on the same day, by the same provider.	narr. of med. necessity, full mouth x-ray(s)

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7282	mobilization of erupted or malpositioned tooth to aid eruption	4 - 23	Teeth 1 - 32	No	May not be paid for the same date of service as D7280.	
D7283	placement of device to facilitate eruption of impacted tooth	1 - 23	Teeth 2-15, 18-31	Yes		narr. of med. necessity, full mouth x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	1 - 23		No		
D7286	incisional biopsy of oral tissue-soft	1 - 23		No		
D7290	surgical repositioning of teeth	1 - 23	Teeth 1 - 32	No		
D7291	transseptal fiberotomy, by report	4 - 23	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	1 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7350	vestibuloplasty - ridge extension	1 - 23	Per Arch (01, 02, LA, UA)	Yes	Limit one service per lifetime, per patient, per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7410	radical excision - lesion diameter up to 1.25cm	1 - 23		No		
D7411	excision of benign lesion greater than 1.25 cm	1 - 23		No		
D7413	excision of malignant lesion up to 1.25 cm	1 - 23		No		
D7414	excision of malignant lesion greater than 1.25 cm	1 - 23		No		
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	1 - 23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee.	
D7441	excision of malignant tumor – lesion diameter greater than 1.25cm	1 - 23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee.	
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	1 - 23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	1 - 23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7465	destruction of lesion(s) by physical or chemical method, by report	1 - 23		No	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee	
D7472	removal of torus palatinus	1 - 23		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	1 - 23	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Not allowed on same day as extraction.	
D7520	incision and drainage of abscess - extraoral soft tissue	1 - 23		No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	1 - 23		No		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	1 - 23		No		

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	1 - 23	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	1 - 23		No		
D7670	alveolus stabilization of teeth, closed reduction splinting	1 - 23		No		
D7820	closed reduction dislocation	1 - 23		No		
D7880	occlusal orthotic device, by report	1 - 23		Yes	Limit one service every five years, per patient.	narrative of medical necessity
D7899	unspecified TMD therapy, by report	1 - 23		Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	1 - 23		No	D7910, D7911, and D7912 will deny if billed on the same date of service with any other D7000 series code.	
D7911	complicated suture-up to 5 cm	1 - 23		Yes	D7911, D7910, and D7912 will deny if billed on the same date of service with any other D7000 series code.	narrative of medical necessity
D7912	complex suture - greater than 5cm	1 - 23		Yes	D7912, D7910, and D7911 will deny if billed on the same date of service with any other D7000 series code.	narr. of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	1 - 23		Yes		narrative of medical necessity

Oral and Maxillofacial Surgery						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D7961	buccal / labial frenectomy (frenulectomy) - separate procedure not incidental to another procedure	12 - 23		Yes		Pre-Operative Radiographs, narrative/treatment plan. Photos optional
D7962	lingual frenectomy (frenulectomy) – separate procedure not incidental to another procedure	1 - 23		Yes		Pre-Op and Post-Op X-rays, narrative/treatment plan. Photos optional
D7970	excision of hyperplastic tissue – per arch	1 - 23	Per Arch (01, 02, LA, UA)	Yes	Limit one service per lifetime, per patient, per arch.	narr. of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	1 - 23	Teeth 1 - 32	No	Limit one service per lifetime, per patient, per arch.	
D7972	surgical reduction of fibrous tuberosity	13 - 23	Teeth 1, 16, 17, 32	No	Limit of two services per lifetime, per patient. Not allowed with extraction of 1, 16, 17, or 32 on the same date of service. May not be paid in addition to D7971 for the same date of service.	narrative of medical necessity
D7980	surgical sialolithotomy	1 - 23		No		
D7983	closure of salivary fistula	1 - 23		No		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	1 - 23		Yes	Limit one service per lifetime, per patient. Not allowed by provider or office that placed the appliance.	narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	1 - 23		Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for STAR Health (Foster Care)
Please see Appendix A-7 for the Texas Orthodontia Review Policy for additional information on definitions, case levels, criteria and requirements for submission. Comprehensive orthodontic services include all of the following: • Diagnostic workups • Banding • Initial brackets • Replacement brackets • Monthly visits • Initial retainers • Special orthodontic treatment appliance(s)” Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Orthodontics						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-23		Yes	Limit one service of (D8010, D8020) per lifetime, per patient. No more than 10 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8020	limited orthodontic treatment of the transitional dentition	0-23		Yes	Limit one service of (D8010, D8020) per lifetime, per patient. No more than 10 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8070	comprehensive orthodontic treatment of the transitional dentition	10-12		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8080	comprehensive orthodontic treatment of the adolescent dentition	12-23		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8090	comprehensive orthodontic treatment of the adult dentition	12-23		Yes	Limit one service of (D8070, D8080, D8090) per lifetime, per patient. No more than 22 adjustments (D8670) allowed. Pre-authorization is required.	models, pano, cephalo, photos
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-12		Yes	Limit two services of (D8210, D8220) per lifetime, per patient. One per arch. Pre-authorization is required.	narrative of medical necessity
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-12		Yes	Limit two services of (D8210, D8220) per lifetime, per patient. One per arch. Pre-authorization is required.	narrative of medical necessity
D8670	periodic orthodontic treatment visit	0-23		Yes	Limit one service per 21 days, per patient. Pre-authorization is required.	models, pano, cephalo, photos
D8680	orthodontic retention (removal of appliances)	0-23		Yes	Limit one service per lifetime, per patient. Pre-authorization is required.	models, pano, cephalo, photos

Exhibit A Benefits Covered for STAR Health (Foster Care)
Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain. Covered dental services that indicate “Yes” in the “Review Required” column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the “Documentation Required” column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member’s file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Box 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations. Services Submitted with D9222 and, D9223, and D9500 for ages 1-6 will require prior authorization. Please reference ‘Criteria for General Anesthesia and Intravenous (IV) Sedation’ in the Clinical Criteria section of this ORM. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
Under 1 TAC §353.409(b) and §353.1001(b) EPSDT regulations, DentaQuest is required to provide the services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under FFS Medicaid. Please refer to the TMPPM for the FFS Medicaid language. However, all requests to exceed listed benefit limitations in this provider manual, must be prior authorized with documentation supporting medical necessity for an increased benefit. **When the need for an exception is established, a narrative explaining the reason for the exception of limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word “EXCEPTION” in Block 35 of the ADA claim form. If the key word “EXCEPTION” is missing from Box 35, the claim may deny for exceeding benefit limitations.**

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-23		No	Emergency service only. The type of treatment rendered must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Not allowed for prescriptions or medication.	Narrative of medical necessity
D9120	fixed partial denture sectioning	1 - 23	Teeth 1 - 32	No		
D9210	local anesthesia not in conjuction with operative or surgical procedures	1 - 23		Yes	Code D9210 is not to be billed in conjunction with operative or surgical procedures, the administration of local anesthetic is inclusive in operative and surgical procedures. Not allowed with D9248. Pre-payment review required.	narrative of medical necessity
D9211	regional block anesthesia	1 - 12		No	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Not allowed with D9248.	
D9211	regional block anesthesia	13 - 23		No	Not allowed with D9248.	
D9212	trigeminal division block anesthesia	1 - 12		No	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Not allowed with D9248.	

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9212	trigeminal division block anesthesia	13 - 23		No	Not allowed with D9248.	
D9222	deep sedation/general anesthesia – first 15 minutes	1-6		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243	narr. of med. necessity, pre-op x-ray(s)
D9222	deep sedation/general anesthesia – first 15 minutes	7-12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243	narrative of medical necessity
D9222	deep sedation/general anesthesia – first 15 minutes	13 - 23		Yes	Limit one service per day, per patient. Once per six calendar months, any provider. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243	narrative of medical necessity

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9223	deep sedation/general anesthesia - each subsequent 15-minute increment	1-6		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15- minute increment	7 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 4 – Pediatric, TX Anesthesia Level 4 – High Risk) to perform this procedure. Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narrative of medical necessity

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9223	deep sedation/general anesthesia - each subsequent 15 -minute increment	13 - 23		Yes	Limit eleven services per day, per patient. Once per six calendar months, any provider. It is to be billed in 15-minute increments totaling three hours per day, when billed with (D9222), for each 15-minute additional increment. D9223 must be billed by the same provider, same claim in conjunction with primary procedure code D9222. Not allowed on same day as D9230 or D9248. D9222 and D9223 cannot be billed on the same day as D9239 and D9243.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	1 - 23		No	Limit one service per day, per patient. Not allowed with D9222, D9223, D9239, D9243 and D9248 on same date of service.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	1 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Limit one service per day, per patient ages 1 and above. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	13 - 23		Yes	Limit one service per day, per patient ages 1 and above. It is to be billed for one 15-minute increment. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15- minute increment	1 - 12		Yes	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 3 or 4 – Pediatric, TX Anesthesia Level 3 or 4 – High Risk) to perform this procedure. Limit five services per day, per patient. It is to be billed in 15-minute increments totaling one and one-half hours per day. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15- minute increment	13 - 23		Yes	Limit five services per day, per patient. It is to be billed in 15-minute increments totaling one and one-half hours per day. Not allowed on same day as D9230 or D9248. D9239 and D9243 cannot be billed on the same day as D9222 and D9223.	narrative of medical necessity
D9248	non-intravenous moderate (conscious) sedation	1 - 12		No	Providers must meet TSBDE requirement for Sedation /Anesthesia of Pediatric Patients (TX Anesthesia Level 2, 3, or 4 – Pediatric, TX Anesthesia Level 2, 3, or 4 – High Risk) to perform this procedure. Limit two services per year, per patient. Denied when submitted for the same date of service as procedure code D9420, any provider. Not allowed with D9222, D9223 D9230, D9239 and D9243.	narr. of med. necessity, pre-op x-ray(s)
D9248	non-intravenous moderate (conscious) sedation	13 - 23		No	Limit two services per year, per patient. Denied when submitted for the same date of service as procedure code D9420, any provider. Not allowed with D9222, D9223 D9230, D9239 and D9243. Pre-authorization is required.	narr. of med. necessity, pre-op x-ray(s)

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 - 23		No	An oral evaluation by specialist of any type who is also providing restorative or surgical services must be submitted as D0160.	
D9410	house/extended care facility call	1 - 23		No	Should be billed as D0160 for specialist who is providing treatment.	
D9420	hospital or ambulatory surgical center call	1 - 23		Yes	Limit two services per year, per patient, per tooth. Dental hospital calls (procedure code D9420) are currently limited to twice per rolling year, per member, any provider. Documentation supporting the reason that dental services could not be performed in the office setting must be retained in the member's record and may be subject to retrospective review and recoupment.	narrative of medical necessity
D9430	office visit for observation -no other services performed	1 - 23		No	No other services allowed. Not to be used for post-operative care.	
D9440	office visit - after regularly scheduled hours	1 - 23		No	Not to be used for post-operative care.	narrative of medical necessity
D9610	therapeutic drug injection, by report	1 - 23		Yes	Limit one service of (D9610, D9612) per day per patient. May notbe submitted with code D9248.	Description of drugs with claim
D9612	therapeutic drug injection - 2 or more medications by report	1 - 23		Yes	Limit one service of (D9610, D9612) per day per patient.	Description of drugs with claim

Adjunctive General Services						
Code	**Brief Description**	**Age Limitation**	**Teeth Covered**	**Review Required**	**Benefit Limitations**	**Documentation Required**
D9630	other drugs and/or medicaments, by report	1 - 23		Yes	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. Not allowed with D9230, D9241,D9248, D9610 or D9920.	narrative of medical necessity
D9910	application of desensitizing medicament	18 - 23		No	Not to be used as a base or a liner.	
D9920	behavior management, by report	0-23		Yes	Limit one service per day, per patient. Denied if billed with D9248, D0120-D0180, D1110, D1120 or D0210-D0363.	narrative of medical necessity
D9930	treatment of complications (post-surgical) – unusual circumstances, by report	1 - 23		Yes		narrative of medical necessity
D9944	occlusal guard – hard appliance, full arch	16 - 23		Yes		narrative of medical necessity
D9950	occlusion analysis-mounted case	13 - 23		Yes		narrative of medical necessity
D9951	occlusal adjustment - limited	13 - 23		No	Limit one service per year, per provider.	
D9952	occlusal adjustment - complete	13 - 23		No	Limit one service per lifetime, per provider.	
D9970	enamel micro-abrasion	13 - 23	Teeth 1 - 32	No	Limit One service per day, per provider.	
D9974	internal bleaching - per tooth	13 - 23	Teeth 1 - 32	No		Narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	1 - 23		Yes		narrative of medical necessity