DSM USA INSURANCE COMPANY INC.

Office Reference Manual

AmeriHealth Caritas - Ohio

PO Box 2906

Milwaukee, WI 53201-2906

(833) 955-3422

www.dentaquest.com

![DentaQuest logo]

ADDRESS AND PHONE NUMBERS

Provider Services
P.O. Box 2906
Milwaukee, WI 53201-2906
833-955-3422

Mail authorizations to:
DENTAQUEST of OH-Authorizations
P.O. 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

Mail claims to:
DENTAQUEST of OH–Claims
PO Box 2906
Milwaukee, WI 53201-2906

Claims questions:
denclaims@dentaquest.com

Electronic claims/authorizations should be sent:
Online via Provider Portal
https://govservices.dentaquest.com/

Eligibility or benefit questions:
denelig.benefits@dentaquest.com

or

Customer Service/Member Services:
Customer Service/Member Services:
833.764.7700
24 Hour Emergency Line: 833.625.6446

Via Clearinghouse
Payer ID CX014
Include the following address:
DentaQuest LLC
P.O. Box 2906
Milwaukee, WI 53201-2906

Fraud Hotline:
800-237-9139

Credentialing:
https://managedcare.medicaid.ohio.gov/

DentaQuest

STATEMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring all members are treated in a manner that respects their rights and acknowledges its expectations of member's responsibilities. The following is a statement of members' rights and responsibilities.

- All members have a right to receive pertinent, up-to-date information about DentaQuest,the managed care services DentaQuest provides, the participating providers and dental offices, as well as member rights and responsibilities.

- All members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.

- All members have the right to fully participate with caregivers in the decision-making process surrounding their healthcare.

- All members have the right to be fully informed about the medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

- All members have the right to voice a complaint against DentaQuest, any of its participating dentaloffices or any of the care provided by these groups or people, when their performance has not metthe Member's expectations.

- All members have the right to appeal any decisions related to patient care and treatment. Membersmay also request an external review or second opinion.

- All members have the right to make recommendations regarding DentaQuest's/plan's members' rights and responsibilities policies.

Likewise:

- All members have the responsibility to provide, to the best of their abilities, accurate information DentaQuest and its participating dentists need to provide the highest quality of healthcare services.

- All members have a responsibility to follow the treatment plans and home care instructions closely forthe care they have agreed upon with their healthcare practitioners.

- All members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

STATEMENT OF PROVIDER RIGHTS AND RESPONSIBILITIES

Dental providers shall have the right to:

- Communicate with patients, including Members, regarding dental treatment options.

- Recommend a course of treatment to a member, even if the course of treatment is not a covered benefit or approved by plan/DentaQuest.

- File an appeal or complaint pursuant to the procedures of plan/DentaQuest.

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

- Object to policies, procedures or decisions made by plan/DentaQuest.

- Notify the member in writing and obtain a signature of waiver if a recommended course of treatment is not covered, e.g., not approved by plan/DentaQuest, and if the provider intends to charge the member for such a non-compensable service.

- Be informed of the status of their credentialing or recredentialing application, upon request.

*   *   *

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

Use of Your Information

You authorize DentaQuest, its affiliates, and its Plans to include your name and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include your name and practice information in their provider directories if required by applicable law. Additionally, your information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Provider Services Agreement or this ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose your information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose your personal information to third parties, we require them to protect the privacy and security of your information

OFFICE REFERENCE MANUAL
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1.00 PATIENT ELIGIBILITY VERIFICATION PROCEDURES

1.01 PLAN ELIGIBILITY

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

1.02 MEMBER IDENTIFICATION CARD

Members receive identification cards from their plan. Participating providers are responsible for verifying that members are eligible at the time services are rendered andto determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice. Members will receive a Plan ID Card.

Sample of AmeriHealth's Ohio 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 healthplan 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 alone does not guarantee a person is currently enrolled in the health plan.

1.03 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 http://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.

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 expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply 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 1-888-308-9345.

Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. 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.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at

1-888-308-9345. 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 by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at 1-888-308-9345.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** 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.

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 1-888-308-9345. They will be able to assist you in utilizing either system.

1.04 STATE ELIGIBILITY SYSTEM

Ohio Department of Job and Family Services

800-686-1516

1.05 SPECIALIST REFERRAL PROCESS

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

1.06 PARTICIPATING HOSPITALS

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Provider should submit services for dental care to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider should use the information below for facility authorization if applicable.

For Medical Prior Authorizations you may contact the Plan directly at 1-833-764-7700 (TTY 1-833-889-6446)

2.00 AUTHORIZATION FOR TREATMENT

2.01 DENTAL TREATMENT REQUIRING AUTHORIZATION

Authorization is a utilization tool that requires 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, plan and agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest' s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the benefits covered to understand the decision-making process used to determine payment for services rendered.

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A. Authorization and documentation submitted before non-emergency treatment begins.

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non- emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member, the plan and/or DentaQuest.

Your submission of documentation should include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)

- CDT codes on the claim form

Your submission should be sent on an ADA-approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A "Yes" in this column indicates the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

B. Submitting authorization requests and X-rays

- Electronic submission using the new web portal

- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit http://www.nea-fast.com/ and click the "Learn More" button. To register, visit https://vynedental.com/fastattach and select "Register Now."

- Submission of duplicate radiographs (which we will recycle and not return)

- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

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

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.

- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.

- Cut out radiographs placed in a coin envelope.

- Multiple radiographs placed in the same slot of a radiograph holder or mount.

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

2.02 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 member's 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 with the claim and payment should be processed.

3.00 CLAIM SUBMISSION PROCEDURES

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.

3.01 SUBMITTING CLAIMS WITH X-RAYS

Acceptable submissions include:

- Electronic submission using the provider web portal

- Electronic submission using National Electronic Attachment (NEA) is recommended.

- Submission of duplicate radiographs (which we will recycle and not return)

- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

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

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.

- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.

- Cut out radiographs placed in a coin envelope.

- Multiple radiographs placed in the same slot of a radiograph holder or mount.

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

3.02 ELECTRONIC CLAIM SUBMISSION UTILIZING DENTAQUEST'S 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'. 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. 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 Provider Services department at 1-888-308-9345.

3.03 ELECTRONIC CLAIM SUBMISSION VIA CLEARINGHOUSE

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 Payor ID: CX014

Include the following address:

DentaQuest LLC

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

3.04 HIPAA COMPLIANT 837D FILE

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

3.05 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/ and provide this information to DentaQuest in its entirety.

All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.

When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual 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.

3.06 PAPER CLAIM SUBMISSION

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

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

The paper claim must contain an acceptable provider signature. The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number. The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a

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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.

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 LLC of OH
Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

3.07 PAYMENT FOR NON-COVERED SERVICES

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

- The services to be provided.

- DentaQuest, plan and Agency will not pay for or be liable for said services, and

- Member will be financially liable for such services.

Once Plan non-coverage has been established, Providers may choose to obtain a written waiver from the Member prior to rendering such service that indicates the services to be provided; and the member will be financially liable for such services. A "**Non-Covered Services Disclosure Form**" template can be found at www.DentaQuest.com and in the Additional Resources section of this document.

3.08 COORDINATION OF BENEFITS (COB)

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

3.09 FILING LIMITS

Claims for OH Medicaid members are timely if received within Three hundred sixty-five days of the actual date the service was provided. (OAC Rule 5160-1-19)

Any claim submitted beyond the timely filing limit specified in the contract will be denied for untimely filing. If a claim is denied for untimely filing, the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

3.10 RECEIPT AND AUDIT OF CLAIMS

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

Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

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

3.11 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 that can be found on the website (www.dentaquest.com) and in the additional resources section of this manual.

- Attach a voided check and W-9 to the form. THE AUTHORIZATION CANNOT BE PROCESSED WITHOUT A VOIDED CHECK.

- COMPLETE THE STANDARD UPDATES FORM that can be found on the website (www.dentaquest.com) and in the additional resources section of this manual.

- Return the Direct Deposit Authorization Form, Standard Updates Form, W-9, and voided check to DentaQuest.

- Via Email: StandardUpdates@DentaQuest.com

- Via Fax: 1-262-241-4077

- Via Mail:

  DentaQuest
  ATTN: PDA Department
  PO Box 2906
  Milwaukee, WI 53201-2906

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:

- Go to www.dentaquest.com

- Once you have entered the website, click on the "Dentist" icon. From there choose your 'State' and press go.

- Log in using your password and ID

- Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".

- The remittance will display on the screen.

4.00 DISPUTE RESOLUTION

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

DentaQuest LLC
Attention: Utilization Management/Provider Appeals
P.O. Box 2906
Milwaukee, WI 53201-2906

All notices received shall be submitted to DentaQuest's Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision.

External Medical Review: For services denied on account of lack of medical necessity, participating providers have the right to file a request for an external medical review, within timely filing limits. Services that are denied for reasons other than lack of medical necessity (e.g., the service is not covered by Medicaid) are not subject to external medical review.

The providers must submit the completed ODM 06653 medical claim review request form (available on ODM's website at medicaid.ohio.gov/resources-for-providers), along with the claim form and all relevant supporting documents, to the following address for review:

Ohio Department of Medicaid, Provider Relations Section
P.O. Box 1461,

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Columbus, OH 43216-1461

DentaQuest will transmit all relevant information to the ODM-identified external medical review entity within five business days of the receipt of the provider's request for an external medical review. The external medical review entity's decision will be final; both DentaQuest and providers must abide accordingly.

4.01 EXTERNAL MEDICAL REVIEW (EMR)

Providers who disagree with the Ohio Medicaid Managed Care Entity's determination on appeal to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity may request an External Medical Review with Permedion. Services denied, limited, reduced, suspended, or terminated for reasons other than lack of medical necessity, and for which we did not complete a medical review, are not subject to external medical review. The request for External Medical Review must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals process has been exhausted. Providers may also request an External Medical Review if the MCE has not met the required Provider Internal Appeal or Provider Claim Dispute resolution time frame for a denial based on medical necessity.

The external medical review process:

- Is available at no cost to the provider

- Does not interfere with the provider's right to request a peer-to-peer review

- Does not interfere with a member's right to request an appeal or state hearing

External Medical Review Process

Providers must complete the Ohio Medicaid MCE External Review Request form and submit to Permedion together with the required supporting documentation. Upload this request form and supporting documentation to Permedion's provider portal (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access). Providers should attach to this request form only additional documents not originally provided to the MCE during their review process. For more information about the External Medical Review process, please contact Permedion at 1-800-473- 0802, Option 2.

Following the external medical review, a letter is sent within:

- 24 hours for requests associated with expedited service authorization decisions

- 30 days for requests associated with standard service authorization decisions

- 60 days for requests associated solely with provider payment(s)

The external medical review decision is final and binding.

5.00 INQUIRIES, COMPLAINTS AND GRIEVANCES (POLICIES 200.010, 200.011, 200.013, 200.017)

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

- **Inquiry**: An inquiry is the first contact with the plan (verbal or written) expressing dissatisfaction from the member, an attorney on behalf of a member or a government agency.

- **Complaint**: A complaint is an expression of dissatisfaction (written or verbal) from a member, an attorney on behalf of a member or a government agency registering a request for review of a prior decision.

- **Grievance**: A notice sent by a member or attorney on behalf of a member registering a request for formal review of a complaint decision. Issues categorized as grievances have progressed through the inquiry, and complaint levels of the process resulting in a member's dissatisfaction with the outcome of issue review.

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

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

Note: Copies of DentaQuest policies and procedures can be requested by calling Customer Service at 855-208-6575. *(Policies 200.010, 200.011,200.013, 200.017)*

5.01 MEMBER COMPLAINT SUBMISSION

Members have the right to submit a complaint to DentaQuest at any time. The complaint can be regarding any dispute the Member or Authorized Representative has with DentaQuest. Members have the right to assign a Representative. The Representative can be any individual of the member's choosing: spouse, family member, attorney, provider, Power of Attorney, guardian, etc.

- The complaint is not required to be written. Verbal requests are accepted and do not require written and signed documentation from the member or Authorized Representatives.

- A member or Authorized Representative can submit a verbal complaint by calling DentaQuest using the designated number with TTY services based on their plan.

- A member's written complaint may be submitted to DentaQuest's Complaints & Grievances

- Department at the following address:

    DentaQuest
    Attn: Complaints & Grievances P.O. Box 2906
    Milwaukee, WI 53201-2906

6.00 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA. DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

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

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

Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-5) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-5 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

6.01 HIPAA COMPANION GUIDE

To view a copy of the most recent Companion Guide please visit our website at 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. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right-hand side of the screen).

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7.00   UTILIZATION MANAGEMENT PROGRAM

7.01 INTRODUCTION

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. 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.

7.02 COMMUNITY PRACTICE PATTERNS

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

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

7.03 EVALUATION

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

- Diagnostic and preventive treatment;

- Patient treatment planning and sequencing;

- Types of treatment;

- Treatment outcomes; and

- Treatment cost effectiveness.

7.04 RESULTS

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance 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.

7.05 FRAUD AND ABUSE

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

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. 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.

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

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

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

If there is any suspicion of Fraud and Abuse, please call the Fraud Hotline at 800-237-9139.

7.06 COMMUNITY PRACTICE PATTERNS

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8.00 QUALITY IMPROVEMENT PROGRAM

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

- Provider credentialing and recredentialing.

- Member satisfaction surveys.

- Provider satisfaction surveys.

- Random Chart Audits.

- Complaint Monitoring and Trending.

- Peer Review Process.

- Utilization Management and practice patterns.

- Initial Site Reviews and Dental Record Reviews.

- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 1-855-398-8411 or via e-mail at denelig.benefits@dentaquest.com.

9.00 CREDENTIALING

Effective Oct. 1, 2022, Ohio Medicaid and MyCare providers will utilize the Provider Network Management (PNM) module from the Ohio Department of Medicaid for submitting provider applications, credentialing request, and provider demographic updates. The PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service. The PNM module is replacing MITS provider portal. Please visit managedcare.medicaid.ohio.gov/ for further details.

A provider must be registered with Ohio Department of Medicaid, have a valid Ohio Medicaid Dental License, Medicaid ID and NPI to contract with DentaQuest.

DentaQuest, in conjunction with the plan, has the sole right to determine which dentists (DDS or DMD) it shall accept and continue as participating providers.

The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of participating providers. DentaQuest considers each provider's potential contribution to the objective of providing effective and efficient dental services to members of the plan.

DentaQuest' s credentialing process adheres to NCQA guidelines as the guidelines apply to dentistry.

Nothing in this credentialing plan limits DentaQuest's sole discretion to accept and discipline participating providers. No portion of this credentialing plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a provider's participation in accordance with the participating provider's written agreement, instead of this credentialing plan.

The plan has the final decision-making power regarding network participation. DentaQuest will notify the plan of all disciplinary actions enacted upon participating providers.

Appeal of Credentialing Committee Recommendations. (Policy 300.017)

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

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

Discipline of Providers (Policy 300.019)

The Credentialing Committee, in its sole discretion or upon recommendation by the Peer Review Committee, may discipline a participating provider for substandard performance, failure to comply with the administrative requirements, or the professional criteria, or any other reason the Credentialing Committee deems appropriate.

Procedures for Discipline and Termination (Policies 300.017-300.025)

Where the Credentialing Committee determines that remedial action was or will be ineffective to the adverse actions, it may suspend, terminate or restrict the participation of a provider and remove them from all network directories.

Recredentialing (Policy 300.016)

All existing providers must be reviewed every 36 months from the date of their previous credentialing action.

Note: DentaQuest policies are available upon request by calling DentaQuest Customer Service at 855-208-6575 or emailing denelig.benefits@dentaquest.com.

10.00 THE PATIENT RECORD

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

   - Registration data including a complete health history.
   - Medical alert predominantly displayed inside chart jacket.
   - Initial examination data.
   - Radiographs.
   - Periodontal and Occlusal status.
   - Treatment plan/Alternative treatment plan.
   - Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
   - 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:

   - Health history.
   - Medical alert.
   - Examination/Recall data.
   - Periodontal status.
   - 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.

10.01 CONTENT - THE PATIENT RECORD MUST CONTAIN THE FOLLOWING:

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

   - Patient's first and last name.
   - Date of birth.
   - Sex.
   - Address.
   - Telephone number.
   - Name and telephone number of the person to contact in case of emergency.

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

   - Current medical treatment.
   - Significant past illnesses.
   - Current medications.
   - Drug allergies.
   - Hematologic disorders

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- Cardiovascular disorders.
- Respiratory disorders.
- Endocrine disorders.
- Communicable diseases.
- Neurologic disorders.
- Signature and date by patient.
- Signature and date by reviewing dentist.
- History of alcohol and/or tobacco usage including smokeless tobacco.

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

   - Significant changes in health status.

4. Current medical treatment.

5. Current medications.

6. Dental problems/concerns.

7. Signature and date by reviewing dentist.

8. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are health problems which contraindicate certain types of dental treatment.

9. Health problems that require precautions or pre-medication prior to dental treatment.

10. Current medications that may contraindicate the use of certain types of drugs or dental treatment.

11. Drug sensitivities.

12. Infectious diseases that may endanger personnel or other patients.

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

    - Blood pressure. (Recommended)

14. Head/neck examination.

15. Soft tissue examination.

16. Periodontal assessment.

17. Occlusal classification.

18. Dentition charting.

19. 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:

- Blood pressure. (Recommended)

20. Head/neck examination.

21. Soft tissue examination.

22. Periodontal assessment.

23. Dentition charting.

24. Radiographs which are:

    - Identified by patient name.

25. Dated.

26. Designated by patient's left and right side.

27. Mounted (if intraoral films).

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

29. 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:

    Procedure.

30. Localization (area of mouth, tooth number, surface).

31. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    - Periodontal pocket depth.

32. Furcation involvement.

33. Mobility.

34. Recession.

35. Adequacy of attached gingiva.

36. Missing teeth.

37. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    - Gingival status.

38. Amount of plaque.

39. Amount of calculus.

40.   Education provided to the patient.

41.   Patient receptiveness/compliance.

42.   Recall interval.

43.   Date.

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

- Provider to whom consultation is directed.

45.   Information/services requested.

46.   Consultant's response.

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

- Date of service/procedure.

48.   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. Type and dosage of anesthetics and medications given or prescribed.

49.   Localization of procedure/observation. (tooth #, quadrant etc.)

50.   Signature of the Provider who rendered the service.

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

- Patient examination.

52.   Treatment plan.

53.   Treatment status.

10.02 COMPLIANCE

A. The patient record has one explicitly defined format that is currently in use.

B. There is consistent use of each component of the patient record by all staff.

C. The components of the record that are required for complete documentation of eachpatient's status and care are present.

D. Entries in the records are legible.

E. Entries of symbols and abbreviations in the records are uniform, easily interpretedand are commonly understood in the practice.

11.00 PATIENT RECALL SYSTEM REQUIREMENTS

A. Recall System Requirement

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

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

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

B. Office Compliance Verification Procedures

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.

- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.

- Urgent care must be available within 72 hours of referral.

- Emergency care must be available within 48 hours.

- Preventative & Routine Care must be available within 30 days of referral.

- Standard wait time in office must not be more than 45 minutes.

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

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<u>Note</u>: Please refer to benefit tables for radiograph benefit limitations.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A.   **Radiographic Examination of the New Patient**

   Child – primary dentition

   The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

   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.

   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.

   Adult – dentulous

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

   Adult – edentulous

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

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

   Patients with clinical caries or other high–risk factors for caries

   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.

   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.

   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.

   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.

C.   **Growth and Development Assessment**

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.

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.

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.

Adult

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

NOTE: **Please refer to benefit tables for benefits and limitations.** Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling (AAPD Reference Manual 2022)

	AGE				
AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal-risk ssessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/ vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

- First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

- By clinical examination.

- Must be repeated regularly and frequently to maximize effectiveness.

- Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

- Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

- Appropriate discussion and counseling should be an integral part of each visit for care.

- Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

- At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.

- At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

- Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.

- Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.

- Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.

- For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

- Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

American Academy of Pediatric Dentistry. Periodicity of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:253-65

14.00 CLINICAL CRITERIA

The criteria outlined in DentaQuest's Provider Office Reference Manual are based on 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, including 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 also meet and satisfy specific state and health plan requirements. 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 in those instances when there may be a special situation.

We hope 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 are 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 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.

The clinical criteria presented in this section are the criteria that DentaQuest will use for making medical necessity determinations for prior authorizations, post-payment review and retrospective review. In addition, please review the general benefit limitations presented in Exhibit A of this manual for additional information on medical necessity on a per code basis.

Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Prior authorization is required for all orthodontic treatment and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center. Some services require pre-payment review, these services are detailed in Exhibit A benefits covered in the "Authorization Required" column.

For all procedures, every provider in the DentaQuest program is subject to random chart/treatment 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 network 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. If radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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.

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.

14.01 CRITERIA FOR DENTAL EXTRACTIONS

Documentation needed for pre-authorization of procedure

- Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth

- Narrative demonstrating medical necessity

- A decision regarding benefits is made based on the documentation provided.

- Treatment rendered without necessary pre-authorization is subject to retrospective review.

- Codes: DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

- Gingival Irrigation, collection and application of autologous blood concentrate product, Placement of intra-socket biologic dressing to aid in hemostasis or clot stabilization, Bone grafting, and exposure of an adjacent unerupted tooth are included in the extraction benefit and are not separately reimbursable.

- Excision of peri-coronal gingiva is included with extraction of same tooth.

Criteria

- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit except when at least one adjacent tooth is symptomatic

- In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.

- Reimbursement for extractions includes removal of tooth, soft tissue associated with the root and curettage of the socket. Periapical granulomas at the apex of teeth will not be separately reimbursed in addition to the extraction. 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 is not separately billable.

- Without documentation of a bleeding disorder, Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction or surgical fee and is not separately billable.

- Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

Documentation needed for authorization procedure

- Diagnostic Quality periapical and/or panoramic radiographs,

- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission

- Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.

- Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of

medical necessity.

Documentation needed for emergent authorization procedure: In emergency situations when prior authorization is not possible, extractions will require review prior to payment.

Documentation requirements for emergent retrospective review will include

- Diagnostic Quality periapical and/or panoramic radiographs.

- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission

- Duplicated radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.

Authorization for extraction of impacted third molars

- Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, D7240, and D7241. All impaction codes are subject to pre-payment review upon submission, preservice or post-service.

- The prophylactic removal of disease-free third molars is not covered except when at least one adjacent tooth is symptomatic

- Impacted third molars that do not show radiographic evidence of root formation are considered pre-eruptive and will not qualify for an authorization for extraction in the absence of pathology, such as dentigerous cysts, OKCs, Ameloblastomas.

- To qualify for the removal of an impacted tooth, the tooth must demonstrate one of the following: Pathology such as pericoronitis, dentigerous cysts, OKCs, Ameloblastomas, or radiographic aberrant tooth position beyond normal variations, or pain beyond normal eruptive pain, as demonstrated by a narrative on a per tooth basis, describing pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain.

- Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.

- Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.

- Lack of root formation is considered pre-eruptive and will not qualify for benefit.

- Excision of pericoronal gingiva is included with extraction of same tooth or adjacent tooth

- Authorization for D7241 will only be authorized during post-service review with a clinical chart note indicating the unusual surgical complication which occurred. Authorization of D7240 will be granted pre-service in-lieu-of D7241, pending post-service review for unusual surgical complications.

Authorization for Surgical Extractions

- Benefit review decisions for authorization of the extraction of teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7210, D7250.

- Surgical extractions of erupted teeth are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and or section of the tooth and closure to remove the tooth. Authorizations for extractions D7210 will not meet criteria if the tooth is single rooted with remaining clinical crown visible in the mouth except in the presence of a root dilaceration, endodontic treatment, or decay.

- Authorizations for extractions D7210 will not meet criteria if the tooth is single rooted with remaining clinical crown visible in the mouth except in the presence of a root dilaceration, endodontic treatment, or decay exceeding 75% of the crown.

- Billed and noted in patient record on a tooth-by-tooth basis.

- Services that fail to meet clinical criteria due prior treatment will require medical necessity review.

References

- American Association of Oral Maxillofacial Surgeons

- American Dental Association

- OAC 5160-5-01 Dental Services (Appendix A to rule 5160-5-01 Oral Surgery)

14.02 CRITERIA FOR CAST CROWNS

Pre-Authorization Documentation

A. Documentation may be needed for pre-authorization of procedure which includes but is not limited to:

1. Periapical x-ray clearly showing the full length of the tooth in review, including the entire clinical crown through the apex of the root.
2. Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth.
3. Treatment rendered without necessary pre-authorization is subject to retrospective review.

Additional Information

A. Crowns are not a covered benefit if:

1. A lesser means of restoration is possible.

2. Tooth has subosseous and/or furcation caries.

3. Tooth has advanced periodontal disease.

4. Tooth does not demonstrate 50% bone support.

5. Tooth has furcation involvement.onlay

6. Tooth is a third molar, unless it is an abutment for a partial denture.

7. Tooth is a primary tooth with exfoliation imminent.

8. Tooth has crown less than five years old which is dislodged, broken or lost and does not meet criteria for medical necessity.

9. Crowns are being planned for cosmetics or to alter vertical dimension. If performed, these must be done with agreement of the patient to assume all costs.

10. Splinted Crowns and double abutments are not allowed.

11. A submission for a cast partial denture was denied due to the overall status of the arch having poor long-term prognosis due to more than half of the remaining teeth requiring major restorative work or more than half of the teeth having less than 50% bone support. Treatment is not considered appropriate when the prognosis of the abutment teeth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement.

Codes

A. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

B. The crown benefit includes preparation, impression, provisional, as well as custom shade, staining, porcelain butt margin, or characterization of the final restoration. Lab rush fee is not separately reimbursable.

Criteria

A. In general, crowns are allowed only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

1. Molars must have destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps, or root canal therapy.

2. Bicuspids must have destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp, or root canal therapy.

3. Anterior teeth must have destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge. Root canal therapy alone may not qualify for a crown, in accordance with recommendations from the American Association of Endodontics.[1]

B. Crown build-up procedures are allowed on teeth that meet crown criteria, where clinical crown breakdown is at a level where the build-up material is necessary for crown retention. Per the CDT code descriptor, buildups are used "when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation."

C. Replacement crowns are allowed only on teeth with recurrent decay or missing crowns. Open margins, in the absence of decay, are considered cleansable and do not require replacement.

D. Under EPSDT or outside of frequency limits, replacement crowns are not benefited due to chipped or fractured porcelain, without decay.

E. Crowns being placed for cosmetic purposes are not a covered benefit.

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[1] American Association of Endodontists (AAE). Endodontics: Colleagues for Excellence Newsletter; Restoration of Endodontically Treated Teeth: The Endodontist's Perspective, Part 1. Spring/Summer 2004

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

    1. One month must have passed since the root canal therapy was completed.

    2. Request must include a dated post-endodontic radiograph.

    3. Tooth must be filled within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.

    4. The filling must be properly condensed/obturated.

    5. To be covered, a tooth must oppose a tooth, crown or denture in the opposite arch or be an abutment for a partial denture.

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

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

14.03 CRITERIA FOR ENDODONTICS

In most cases, no prior authorization is required. A dated post-operative radiograph must be submitted for retrospective review.

Codes

DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

Reimbursement for Root Canals includes surgical placement of a rubber dam, intraorifice barrier and pulpectomy or pulpotomy done by the same provider group.

Criteria

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

Root canal therapy must meet the following criteria:

- Fill must be within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits ability to fill canal to apex.
- Fill must be properly condensed/obturated.
- Filling material must not extend beyond the apex.

Root canal therapy is not a covered benefit in the following situations:

- 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.

- Third molars, unless they are an abutment for a partial denture
- Tooth does not demonstrate 50% bone support
- Tooth has furcation involvement
- When performed in anticipation of placement of an overdenture
- Using filling material not accepted by the Federal Food and Drug Administration (FDA),e.g. Sargenti filling material
- A cast partial denture was denied due to excessive restorative needs or poor bone support indicating that the overall health of the teeth and periodontium is not good.

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

In cases where the root canal filling does not meet ADA or American Association of Endodontists (AAE) treatment standards (https://www.aae.org/specialty/clinical- resources/guide-clinical-endodontics/). 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.

Medical necessity of the root canal should be documented in the patient chart. Appropriate thermal test results should be documented on a per tooth basis.

Placement of an Intraorifice Barrier considered part of the endodontic procedure and is not separately billable.

- Apicoectomy will only be approved if following ADA and AAE standards.

- Surgical exposure of root surface will only be approved if following ADA and AAE standards.

- Canal preparation and fitting of preformed dowel or post will only be approved if following ADA and AAE standards.

References:

- American Dental Association

- American Society of Endodontics

- OAC 5160-5-01 Dental Services

- Appendix A to rule 5160-5-01 Endodontic Services

14.04 CRITERIA FOR STAINLESS STEEL CROWNS

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

Documentation needed for review of procedure:

Appropriate radiographs or digital photographic images showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Narrative demonstrating medical necessity if radiographs are not available.

Criteria

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

- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.

- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.

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

14.05 CRITERIA FOR REVIEW OF OPERATING ROOM (OR) CASES

Documentation needed for authorization of procedure:

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

- Narrative describing medical necessity for OR.

All Operating Room (OR) Cases Must be Authorized.

Providers should refer to section 3.00, Participating Hospitals for further clarification on hospital authorization procedures.

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, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).

- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the

availability of resuscitative equipment is necessary during extensive dental procedures.

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.

- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 CRITERIA FOR GENERAL ANESTHESIA AND IV SEDATION

DentaQuest adheres to the following policy for evaluating and approving anesthesia during dental treatment including Local Anesthesia, General Anesthesia and IV Sedation to maintain consistency throughout its dental networks.

Lesser forms of anxiolysis, such as nitrous oxide and oral conscious sedation are included in the General Anesthesia and IV Sedation benefit and are not separately reimbursable.

GENERAL ANESTHESIA

Documentation may be needed for pre-authorization of procedure

- Treatment plan (pre-authorized if necessary)

- Narrative describing medical necessity for General Anesthesia or IV Sedation.

- Treatment rendered under emergency conditions, when pre-authorization is not possible, requires submission of a treatment plan and narrative of medical necessity for retrospective review and payment.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

Criteria

In most cases requests for general anesthesia or IV sedation are authorized (for procedures Covered by health plan) if any of the following criteria are met:
1. Extensive or complex oral surgical procedures such as:
   a. Four (4) or more simple and/or surgical extractions in more than one quadrant in one appointment.
   b. Impacted wisdom teeth.
   c. Surgical root recovery from maxillary antrum.
   d. Surgical exposure of impacted or unerupted cuspids.
   e. Radical excision of lesions more than 1.25 cm.

2. And/or one of the following medical conditions may apply:
   a. Underlying hazardous medical condition (autism, cerebral palsy, epilepsy, intellectual disability,

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Down's syndrome), which would render patient non-compliant.

b. Documented failed local anesthetic or a condition where severe periapical infection would render local anesthesia ineffective, demonstrated radiographically or through clinical chart notes.

c. Acute situational anxiety in patients, demonstrated by a brief patient-specific narrative.

d. Patient is less than 3 years old.

3. Extensive as mentioned above, is defined as procedures which in number, complexity, risk, and/or duration make treatment in a routine ambulatory and conscious state, difficult and/or unsafe potentially leading to harm or failure.

LOCAL ANESTHESIA

Documentation

- Documentation is generally not required when local anesthesia is being prior authorized in conjunction with dental treatment.

- Narrative describing medical necessity may be required if local anesthesia is being performed without dental treatment.

- Local anesthesia performed not in conjunction with dental treatment under emergency conditions, when pre-authorization is not possible, may require submission of a treatment plan and narrative of medical necessity for retrospective review.

Criteria

- Local Anesthesia including local anesthetic injections for regional nerve blocks, local tissue infiltration and topical anesthetic sprays and gels are considered an integral part of completing dental treatment. These services are considered unbundled when submitted separately from the dental treatment service and are disallowed.

Additional Information

- All Claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For these services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Reference

- OAC 5160-5-01 Dental Services

- Appendix A to rule 5160-5-01 Other Services

- American Board of Pediatric Dentistry

14.07 CRITERIA FOR ADMINISTRATION OF NITROUS OXIDE

DentaQuest adheres to the following policy for evaluating approving General Anesthesia and IV Sedation to maintain consistency throughout its dental networks.

Documentation May be Needed for Pre-Authorization of Procedure

- Treatment plan (pre-authorized if necessary)

- Member-specific narrative describing medical necessity for use of nitrous oxide.

- Treatment rendered under emergency conditions, when pre-authorization is not possible, requires submission of a treatment plan and narrative of medical necessity for retrospective review and payment.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

Criteria

In most cases requests for nitrous oxide are authorized (for procedures covered by health plan) if any of the following criteria are met:

1. Extensive or complex procedures such as:
   a. Four (4) or more simple and/or surgical extractions
   b. Impacted wisdom teeth
   c. Surgical root recovery from maxillary antrum
   d. Surgical exposure of impacted or unerupted cuspids
   e. Radical excision of lesions in excess of 1.25 cm.

2. One or more of the following medical conditions may apply:
   a. Documented failed local anesthetic or a condition where severe periapical infection would render local anesthesia ineffective, demonstrated radiographically or through clinical chart notes.
   b. Acute situational anxiety in patients, demonstrated by a brief patient-specific narrative.
   c. Patient is less than 3 years old.
   d. Patients less than 9 years of age must have multiple teeth with extensive procedures, demonstrated by a treatment plan.

- Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- American Association of Oral Maxillofacial Surgeons

- American Dental Association

- American Academy of Pediatric Dentistry

- OAC 5160-5-01 Dental Services

- Ohio Administrative Code 5160-1-01 Medical Necessity

14.08 CRITERIA FOR REMOVABLE PROSTHODONTICS (FULL AND PARTIAL DENTURES)

DentaQuest adheres to the following policy for evaluating and approving full and partial dentures to maintain consistency throughout its dental networks.

Documentation May be Needed for Pre-Authorization of Procedure

- Treatment plan

- Sufficient radiographs that clearly show the adjacent and opposing teeth must be submitted for pre-authorization; bitewings, periapical or panorex.

- Treatment rendered without necessary pre-authorization requires sufficient radiographs that clearly show the adjacent and opposing teeth be submitted for retrospective review and payment; bitewings, periapical or panorex.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

Criteria

- Prosthetic services are intended to restore oral form and function due to 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.

- Partial dentures are covered only for recipients free from active and advanced periodontal and other active and advanced oral disease.

- Radiographs must show no untreated caries 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.

- Authorized when there is one missing anterior tooth and/or 3 missing posterior teeth.

- Approval for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) periodontally sound (a minimum of 50% bone support from the remaining teeth, in particular the abutment teeth, with good position relative to angulation and place in the arch to support the partial) posterior teeth in fairly good position and occlusion with opposing dentition. Approval for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing.

Removable prosthesis is not a covered benefit

- Removable prosthesis is not a covered benefit If there is a pre-existing prosthesis which is not at least 8 years old unless EPSDT applies where provider can demonstrate medical necessity. "MEDICAL NECESSITY" may

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include such circumstances as unserviceability – examples include inability of patient to talk or chew with denture; evidence of ill-fitting dentures which show demonstrable tissue destruction or unusual tissue growth.

- If a favorable prognosis is not present: active and advanced periodontal and other active and advanced oral disease.

- If there are untreated caries or active periodontal disease in the abutment teeth.

- If abutment teeth are less than 50% supported in bone.

- Unless either (1) the absence of several teeth in the arch severely impairs the ability to chew or (2) the absence of anterior teeth affects the appearance of the face per Other Condition or Restriction of Appendix A to Rule 5160-5-01.

- A prescription for dentures must be based on the total condition of the mouth, the patient's ability to adjust to dentures, and the patient's desire to wear dentures. Natural teeth that have healthy bone, are sound, and do not have to be extracted must not be removed.

- Per Appendix A to Rule 5160-5-01, Prosthodontic Services header. If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

- If a partial denture 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.

Benefit Limits

- Adjustments, manufacturer defect repairs and relines are included with the denture fee within the first 6 months after insertion.

- Per Appendix A to rule 5160-5-1, other condition or restriction for relines and Prosthodontic Services header, "The provider is responsible for constructing a functional denture. Payment for a denture or denture service includes all necessary follow-up corrections and adjustments for a period of 6 months."

- After that time has elapsed:

- Relines are compensable once per denture every 36 months when medically necessary or when EPSDT applies.

- A new prosthesis is not compensable within 24 months of reline or repair of the existing prosthesis except when medical necessity and/or EPSDT apply.

- Preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) are not a covered benefit.

- The fee for complete and partial dentures includes six months of post-insertion follow-up care including adjustments, repairs and relines.

- All prosthetic appliances are inserted in the mouth and adjusted before a claim is submitted for payment per OAC 5160-5-01(E)(2) For prosthetic appliances that are not delivered after multiple attempts were made to

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reach the member, payment for lab fees will be made using code D5899 with the appropriate arch, submitted lab receipt, dated with member's name.

- When billing for partial and complete dentures, dentists must list the date that the final impressions were taken as the date of service. Recipients must be eligible on the date the final impressions are taken for the denture service to be covered.

- Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- American Association of Prosthodontics

- American Dental Association

- OAC 5160-5-01 Dental Services (Appendix A to rule 5160-5-01 Prosthodontic Services)

14.09 CRITERIA FOR THE EXCISION OF BONE TISSUE

To ensure the proper seating of a removable prosthesis (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthetic. 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 prosthodontic treatment.

Codes related to the removal of exostoses are subject to prior authorization and may be compensable when submitted in conjunction with appropriate documentation. These determinations are made by the dental specialist/Consultant.

- Alveoloplasty is covered only in conjunction with the construction of a prosthodontic appliance

Prior authorization requirements

- Radiographs (bitewings, periapical or panorex) and/or intraoral photographs and bone scans, which clearly identify the exostoses, must be submitted.

- Treatment plan – includes prosthetic plan.

- Narrative of medical necessity, if appropriate.

Reimbursement

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Reference

- Ohio Administrative Code 5160-5-01 Dental Services

- Ohio Administrative Code 5160-5-01 Oral Surgery - Appendix A

- Ohio Administrative Code 5160-1-01 Medical Necessity

14.10 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. Clinical guidelines have been formulated for the Dental Consultant to ensure that an appropriate determination of benefits is made. 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 root has furcation involvement

- 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 tooth has root resorption

- The root is fractured

- The overall dental condition of the patient is such that an alternative treatment for the tooth would be in the best interest of the patient.

14.11 CRITERIA FOR DIRECT RESTORATION

Review is only performed under EPSDT and post-payment audit.

Documentation required in patient record

- Panorex, bitewing radiographs or periapical radiographs showing entire tooth (teeth) to be restored.

- Narrative demonstrating medical necessity

    a. A decision regarding benefits is made based on the documentation provided.
    b. Treatment rendered without supporting documentation is subject to retrospective review.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

Criteria

- Tooth (teeth) must demonstrate decay into dentin on at least one surface to be restored.

- Direct restorations are limited to one per surface per tooth, except Maxillary first and second molars, the occlusal surface can be named twice, and anterior teeth, the facial and lingual surfaces can be named twice.

- Tooth (teeth) must meet the DentaQuest restorable tooth criteria.[1]

- Replacement restorations must have recurrent decay or material failure. It is DentaQuest's

  expectation that replacement prior to published frequency remain the responsibility of the treating provider.

- Payment is based on tooth and restored surfaces.

- Materials used must meet standards of good dental practice. No payment will be made if materials are used in a manner contraindicated by manufacturer instructions.

- Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- OAC 5160-5-01 Dental Services

- Appendix A to rule 5160-5-01 Restorative Service

14.12 CRITERIA FOR PERIODONTAL TREATMENT

Documentation may be needed for pre-authorization of procedures.

- Loss of clinical attachment, including radiographic evidence of bone loss (type of pre-operative radiographs required varies with plan – full mouth preferred and most current Bitewing radiographs)

- Pre-operative periodontal charting (When periodontal charting is requested for surgical and non-surgical procedures it must be submitted with a periodontal chart dated no more than twelve (12) months prior to the date of service).

- Detailed treatment plan

- Treatment Records

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual. Decisions regarding benefits are made based on the documentation provided.

- Periodontal scaling and root planing, (D4341, D4342) 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.

- Gingival Irrigation is included as part of the Periodontal Scaling and Root Planing benefit and is not separately reimbursable.

Criteria

- According to the American Academy of Periodontology, "scaling and root planing procedures are intended to be used for scaling and root planing, not for scaling alone, so there must be some loss of attachment. Otherwise, these is no exposed root surface to plane". Even if appropriate probing depths (usually > 4mm are present, if there is no attachment loss, root planning cannot be accomplished so codes D4341/D4342 should not be submitted for payment). Periodontal scaling is prescribed/performed for patients who exhibit radiographic evidence of bone loss (2.5 mm from CEJ to crest of bone) or root surface calculus.

- Benefits for periodontal services are available only when billed for natural teeth.

- Prophylaxis procedures (D1110), (D1120), full mouth scaling (D4346) or Gross Debridement (D4355) are considered a component when submitted on the same date of service as Scaling and Root Planing.

- To qualify for periodontal procedures, the tooth must not have less than 50% bone support, furcation involvement, or class II+ mobility.

- All periodontal procedures include routine postoperative care and local anesthesia.

- D4355 is not to be completed on the same day as D0150, D0160, or D0180.

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

References

- Ohio Administrative Code 5160-5-01 - Dental Services

- Ohio Administrative Code 5160-5-01 – Periodontic Services - Appendix A

- American Academy of Periodontology

14.13   CRITERIA MAIL ORDER ORTHODONTICS

OAC 5160-5-1 (C)(2) details eligible Medicaid providers that may receive Medicaid payment for submitting a claim for a dental service. Direct to consumer mail order orthodontics is unsupervised orthodontics, and ineligible to receive Medicaid reimbursement.

Rationale

Orthodontic benefits are payable only for services performed by a licensed dentist. This requirement is imposed primarily for member protection, as it ensures that any procedures performed are necessary, appropriate, and delivered within the

standards of good dental practice. In the case of many mail-order aligner kits, a dentist does not physically examine or oversee the patient care as he or she self-administers a series of orthodontic aligners at home. It is especially important that a dentist monitor the patient during orthodontic treatment, since refinements, revisions and adjustments of aligners are expected and very common. A dentist has the ability and requisite training to properly monitor treatment progress, which is imperative in orthodontic treatment.

Additional Information

- Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- OAC 5160-5-01 Dental Services(C)(2)

14.14   RADIOGRAPHIC CRITERIA

Radiographic Examination of the New Patient

- Child - Primary Dentition (with closed proximal contacts): Posterior bitewings

- Child - Transitional Dentition: Individualized Periapical/Occlusal series with posterior bitewings OR Panoramic X-ray with posterior bitewing

- Adolescent (Ages 16-19; permanent dentition prior to eruption of third molars): Individualized examination consisting of selected periapical and posterior bitewings

- Adult - Dentulous: Individualized examination consisting of selected periapical with posterior bitewings

- Adult - Edentulous: Individualized examination consisting of Panoramic X-ray or Periapical Series of such quality that all relevant structures of the oral cavity (including possible impacted teeth and/or root tips) may be viewed.

Radiographic Examination of the Recall Patient

All radiographs and x-rays will follow the ALARA (As Low As Reasonably Achievable) Principle:

https://www.cdc.gov/nceh/radiation/alara.html#:~:text=ALARA%20stands%20for%20%E2

%80%9Cas%20low,ti me%2C%20distance%2C%20and%20shielding

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

- Child – Primary and Transitional Dentition: Posterior bitewings at a 6-12-month interval

- Adolescent (ages 16-19): Posterior bitewings at a 6-12-month interval

- Adult – Dentulous: Posterior Bitewings at 6-12-month interval

- Adult – Edentulous: Examination for occult disease in this group cannot be justified based on prevalence, morbidity, mortality, radiation dose, and cost. Therefore, DentaQuest recommends that no radiographs be obtained for edentulous recall patients without clinical signs and symptoms.

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

- Child – Primary dentition (with closed proximal contacts): Posterior bitewings at 12-24-month interval

- Adolescent (ages 16-19): Posterior bitewings at 12-24-month interval

- Adult – Dentulous: Posterior bitewings at 24-36-month intervals

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

D. Individualized radiographic survey consisting of selected periapical and/or bitewings of areas with clinical evidence or a history of periodontal disease (except nonspecific gingivitis).

E. Growth and Development Assessment:

- Child – Primary Dentition: No radiographs prior to the eruption of the first permanent tooth at recall visits in the absence of clinical signs or symptoms.

- Child – Transitional Dentition: At first recall visit after the eruption of the first permanent tooth, individualized periapical/occlusal series, or panoramic X-ray

- Adolescent (ages 16-19): Single set of periapical of the third molars or panoramic X-ray

- Adult: DentaQuest recommends that no radiographs be obtained in the absence of clinical signs or symptoms.

- In the absence of clinically detectable growth and development abnormalities, radiographs for growth and development purposes are not allowable.

Reimbursement

- Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation.

- Reimbursement for 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 with the federal policies relating to radiation exposure. DentaQuest uses the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were published in conjunction with the Food and Drug Administration.

- DentaQuest requires that, to be reimbursed, radiographs must meet quality standards of readability. In cases where a radiograph does not meet DentaQuest's treatment standards, DentaQuest can require that the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Dental Consultant reviews the circumstances.

- Additional radiographic views, digitally rendered from a single exposure, are not separately reimbursable.

- Radiographs should be labeled, identified by patient name, dated, designated by patient's left and right side,

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and mounted if intraoral films.

- In accordance with the ADA and FDA's Recommendations for patient selection and limiting radiation exposure, "Dentists should conduct a clinical examination, consider the patient's oral and medical histories, as well as consider the patient's vulnerability to environmental factors that may affect oral health before conducting a radiographic examination." Reimbursement will not be made for radiographs taken without examination and/or prescribed without clinical necessity.

- Cone Beam CT (CBCT)'s are only a benefit for approved implant cases, skeletal fractures, craniofacial anomalies, or pathology when conventional radiographs are insufficient to evaluate the service.

- Procedures that may meet clinical criteria for approval may be disallowed due to frequency limitations except when EPSDT applies. Services that fail to meet clinical criteria due to prior treatment will be disallowed.

References

- Center for Devices and Radiological and the American Dental Association Ohio Administrative Code 5160-5-01 Dental Services

- Ohio Administrative Code 5160-5-01 Diagnostic Imaging, Including Interpretation - Appendix A

14.15 NON-RESTORABLE TOOTH CRITERIA

Criteria

- Tooth (teeth) must demonstrate decay into dentin on at least one surface to be restored.

- Direct restorations are limited to one per surface per tooth, except Maxillary first and second molars, the occlusal surface can be named twice, and anterior teeth, the facial and lingual surfaces can be named twice.

- Tooth (teeth) must meet the DentaQuest restorable tooth criteria.

- Replacement restorations must have recurrent decay or material failure. It is DentaQuest's expectation that replacement prior to published frequency remain the responsibility of the treating provider.

- Payment is based on tooth and restored surfaces.

- Materials used must meet standards of good dental practice. No payment will be made if materials are used in a manner contraindicated by manufacturer instructions. E. Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- OAC 5160-5-01 Dental Services

- Appendix A to rule 5160-5-01 Restorative Service

14.16 CRITERIA FOR FIXED PROSTHODONTICS

Pre-Authorization Documentation

Documentation may be needed for pre-authorization of procedure:

- Detailed Treatment plan.

- Radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapical or panorex.

- Treatment rendered without necessary authorization requires radiographs showing clearly the adjacent and opposing teeth to be submitted with the claim for review for payment.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

General Criteria

- The placement of a fixed prosthetic appliance will only be considered for those cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.

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

Fixed partial dentures are covered only for recipients with:

- AAP Type 1 or 2 periodontal health

- a favorable prognosis where continuous deterioration is not expected as defined in the DentaQuest Non-Restorable Tooth Criteria.[2]

- As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

Criteria

- Authorizations for prosthesis do not meet criteria:

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present. Non-AAP Type 1 or 2 periodontal health is considered an unfavorable prognosis.

- If abutment teeth are less than 50% supported in bone.

- If there are untreated cavities or active periodontal disease in the abutment teeth. Treatment must be phased

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[2] AM-UM01- Exhibit I – Non-Restorable Tooth Criteria Non-Restorable Tooth Criteria

appropriately with stable periodontal status.

- When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.

- Double abutments are not authorized for fixed prosthetics.

Additional Information

- Services that fail to meet clinical criteria due to prior treatment will require medical necessity review.

Reference

- American Association of Prosthodontics

- American Dental Association

- OAC 5160-5-01 Dental Services

14.17 FRENECTOMY CRITERIA (FRENULECTOMY OR FRENOTOMY)

Frenectomies treating failure to latch, or speech disorders may be considered under the medical plan.

Maxillary Frenectomy

- Documentation required for patient's clinical record:

- Must provide a narrative confirming medical necessity (see criteria below)

- For ages 0-18 months, a letter from a physician is necessary to establish medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Any available documentation from speech pathologists, pediatricians, oral surgeons, or otolaryngologists should be provided.

- Digital photographs must be provided.

Mandibular Labial Frenectomy Documentation required for patient's clinical record:

- Must provide narrative confirming medical necessity (see criteria below)

- For ages 0-18 months, a letter from a physician is necessary to establish medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Any available documentation from speech pathologists, pediatricians, oral surgeons, or otolaryngologists should be provided.

- Digital photographs must be provided.

Mandibular Lingual Frenectomy Documentation required for patient's clinical record:

- Must provide narrative confirming medical necessity (see criteria below).

- For ages 0-18 months, a letter from a physician is necessary to establish medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Any available documentation from speech pathologists, pediatricians, oral surgeons, otolaryngologists should be provided.

- Digital photographs must be provided.

Criteria

Maxillary frenectomy:

- With Diastemas, treatment should not be rendered until the permanent incisors and cuspids have fully erupted and any diastema has had an opportunity to close naturally, only benefited with approved orthodontic treatment.

- For infants aged 0-18 months, a letter from a pediatrician is necessary to establish a medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Frenectomies should not be performed prior to denture placement. Necessity will be based on documented failure to retain the denture despite adjustments.

Mandibular labial frenectomy:

- Treatment should be considered if the position of the mandibular labial frenum is causing inflammation, recession, pocket formation, and possible loss of the alveolar bone and/or tooth.

- For infants aged 0-18 months, a letter from a pediatrician is necessary to establish a medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Frenectomies should not be performed prior to denture placement. Necessity will be based on documented failure to retain the denture despite adjustments.

Mandibular lingual frenectomy:

- For infants aged 0-18 months, a letter from a pediatrician is necessary to establish a medical necessity diagnosis of failure to latch in which a frenectomy would alleviate the condition.

- Frenectomies should not be performed prior to denture placement. Necessity will be based on documented failure to retain the denture despite adjustments.

- If it is suspected that the position of the lingual frenum is a contributing factor in altered speech patterns, a letter from a speech pathologist, pediatrician, oral surgeon, or otolaryngologist must be included with the claim.

Additional Information

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Reference

- OAC 5160-5-01 Dental Services

- Identification and Management of Ankyloglossia and Its Effect on Breastfeeding in Infants: Clinical Report, American Academy of Pediatrics, 29 July 2024.

14.18   IMPLANT CRITERIA

General Guidelines

Documentation needed for pre-authorization of procedure

- Narrative of medical necessity

- Full mouth radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapical or panorex.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association's Current Dental Terminology User's Manual.

Criteria

- Authorizations for prosthesis do not meet criteria if there is a lower-cost alternative that effectively addresses and treats the medical problem.

Additional Information

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Reference

- OAC 5160-5-01 Dental Services

- OAC 5160-1-01 Medicaid Medical Necessity: Definitions and Principles

14.19 ONLAY CRITERIA

DentaQuest adheres to the following policy for evaluating onlay restorations to maintain consistency throughout its dental networks.

Pre-Treatment Documentation

- Documentation may be needed for pre-service review of procedure:

- Periapical x-ray clearly showing the full length of the tooth in review, including the entire clinical crown through the apex of the root.

- Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth.

- Treatment rendered without the necessary pre-service review is subject to retrospective review.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

Criteria

- In general, onlays are allowed only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

- Molars must have destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps.

- Bicuspids must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp.

- Build-up procedures are not allowed in conjunction with onlays.

- A request for an onlay following root canal therapy must meet the following criteria:

- One month must have passed since the root canal therapy was completed.

- Request must include a dated post-endodontic radiograph.

- Tooth must be filled within two millimeters of the radiological apex 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.

- To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.

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

- The fee for onlays includes the temporary restoration that is placed on the prepared tooth and worn while the onlay restoration is being fabricated.

- The procedure/treatment must follow medical necessity OAC 5160-1-01.

Onlays will not benefit if

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.

- Tooth has advanced periodontal disease.

- Tooth does not demonstrate 50% bone support.

- Tooth has furcation involvement.

- Tooth is a third molar, unless it is an abutment for a partial denture.

- Tooth is a primary tooth with exfoliation imminent.

- Tooth has restoration less than five years old, which is dislodged, broken or lost; except when medical necessity and/or EPSDT apply.

Additional Information

- Onlays are being planned to alter vertical dimension. If performed, these must be done with agreement of the patient to assume all costs. Such procedures include but are not limited to restorations, procedures or applications done primarily to treat attrition, realign the dentition, splinting, full-mouth rehabilitation or equilibration, and the treatment of TMD Syndrome.

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

- The procedure/treatment must follow medical necessity OAC 5160-1-01.

Reference

- OAC 5160-5-01 Dental Services

- Appendix to rule 5160-5-01 Restorative Services

14.20 VENEER CRITERIA

DentaQuest adheres to the following policy for evaluating veneers to maintain consistency throughout its dental networks.

Pre-Treatment Documentation

Documentation may be needed for pre-service review of procedure:

- Periapical x-ray clearly showing the full length of the tooth in review, including the entire clinical crown through the apex of the root.

- Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth

- Treatment rendered without necessary pre-service review is subject to retrospective review.

Codes

- DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental

Terminology User's Manual.

Criteria

- In general, veneers are allowed only for anterior teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

- 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.

- Build-up procedures are not allowed in conjunction with veneers.

- A request for a veneer following root canal therapy must meet the following criteria:

  – One month must have passed since the root canal therapy was completed.

  – Request must include a dated post-endodontic radiograph.

  – Tooth must be filled within two millimeters of the radiological apex 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.

  – To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.

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

  – The fee for veneers includes the temporary restoration that is placed on the prepared tooth and worn while the veneer is being fabricated.

Additional Information

- Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Reference

- OAC 5160-5-01 Dental Services

14.21 ORTHODONTIC CRITERIA

Coverage of comprehensive orthodontic service is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychological impact on the patient.

Orthodontic service is considered to be medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Medical necessity is determined using the Ohio Orthodontic Criteria for Medical Necessity Form. The demonstration of the presence of one of the following conditions qualifies for comprehensive orthodontic treatment.

- Deep impinging overbite that shows palatal impingement of the majority of lower incisors.

- Anterior openbite (skeletal) involving 3 or more fully erupted teeth – viewed from a frontal view.

- Demonstrates an anterior-posterior discrepancy. Class II or III malocclusions that are a full tooth (greater than full step) Class II or Class III.

- Anterior crossbite of 3 or more teeth in the same arch (Maxillary).

- Posterior transverse discrepancies. (Involves 3 or more maxillary posterior teeth in crossbite, one of which must be a permanent molar).

- Posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).

- Impacted anteriors that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where canines are going to erupt ectopically).

- Documented Psychological, Speech, or Eating Disorders that would be ameliorated by orthodontia. Documented from professionals within their scope of practice.

Purely cosmetic orthodontic service is not covered.

DentaQuest shall deny any orthodontic prior authorization requests when the submitted documentation demonstrates potential compromised outcomes as evidenced by active carious lesions, acute gingivitis, acute periodontitis, poor oral hygiene, or other unresolved dental factors that could result in poor orthodontic case success. Compliance with oral hygiene, dental treatment plans, and appointment attendance are paramount to achieving a favorable outcome.

- All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. Documented cleft palate cases (and other co-specfied conditions) are automatically approved.

- Treatment does not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the patient, or face termination of their Provider Agreement.

Required Documentation

- Lateral and frontal photographs of the patient with lips together.

- Cephalometric film with lips together, including a tracing (required measures per AAO standards).

- A complete series of intraoral images.

- At least one diagnostic model.

- Treatment plan, including the projected length and cost of treatment.

- A completed evaluation and referral form, the ODM 03630.

Reference

OAC 5160-5-01 Dental Services (Appendix A to rule 5160-5-01 Orthodontic Services)

The documented presence of a single condition below qualifies for approval. The presence of the auto-qualifying condition is verified by Dental Consultant review based on submitted documentation.

Ohio Department of Medicaid
REFERRAL EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Individual	Provider
Name	Name
Medicaid ID number	Medicaid provider number
Date of birth	NPI

Mark all symptoms and indications that you observe in this patient.

Dentofacial Abnormality
- ☐ Marked protrusion of upper jaw and teeth
- ☐ Underdevelopment of lower jaw and teeth, receding chin
- ☐ Excessive spacing of front teeth
- ☐ Protrusion of upper or lower teeth such that lips cannot be brought together without strain
- ☐ Marked protrusion of lower jaw and teeth
- ☐ Marked crookedness, crowding, irregularity, or overlapping of teeth
- ☐ Marked asymmetry of lower face or transverse deficiency
- ☐ Cleft of lip or palate
- ☐ Abnormality of dental development
- ☐ Condition that increases likelihood of injury to teeth
- ☐ Condition that complicates or exacerbates TMJ dysfunction or another medical problem
- ☐ Other (Explain on the reverse side of the page.)

Tissue Damage Related to Maloccluded, Misaligned, or Malposed Teeth
- ☐ Marked recession of gums
- ☐ Loosening of permanent teeth
- ☐ Other (Explain on the reverse side of the page.)

Mastication Problem Related to Maloccluded, Misaligned, or Malposed Teeth
- ☐ Marked grimacing or motions of the oral-facial muscles when swallowing or difficulty in swallowing
- ☐ Socially unacceptable eating behavior caused by necessary compensation for anatomic facial deviations
- ☐ Pain when eating
- ☐ Other (Explain on the reverse side of the page.)

Respiration or Speech Problem Related to Maloccluded, Misaligned, or Malposed Teeth
- ☐ Postural abnormalities with associated breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth-breathing
- ☐ Lisping, articulation errors, or other speech impairment
- ☐ History of or recommendation for speech therapy
- ☐ Other (Explain on the reverse side of the page.)

Adverse Psychosocial Impact Related to Maloccluded, Misaligned, or Malposed Teeth
- ☐ (Explain on the reverse side of the page. Supporting statements may be attached from professionals, the patient, or the patient's family concerning the adverse impact on self-image, social interaction, or other psychological or social aspect of life.)

Signature	Date

ODM 03630 (Rev. 1/2016)

APPENDIX A

GENERAL DEFINITIONS

The following definitions apply to this Office Reference Manual:

- **"ODM"** means the Ohio Department of Medicaid.

- **"Contract"** means the document specifying the services provided by DentaQuest to:

- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

- **"Covered Services"** is a dental service or supply that satisfies all of the following criteria:

  - provided or arranged by a Participating Provider to a Member;
  - authorized by DentaQuest in accordance with the Plan Certificate; and
  - submitted to DentaQuest according to DentaQuest's filing requirements.

- **"DentaQuest"** shall refer to DentaQuest USA Insurance Company, Inc.

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

- **"Member"** means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

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

- **"Plan"** is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.

- **"Plan Certificate"** means the document that outlines the benefits available to Members.

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

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

ADDITIONAL RESOURCES

To view copies of the resources below please visit our website at www.DentaQuest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your "State". You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Authorization for Dental Treatment
- Medical and Dental History Form
- Request for Transfer of Records
- Initial Clinical Exam - Sample Form
- Recall Examination - Sample Form
- Dental Claim Form
- Orthodontic Authorization Submission Requirements
- Ohio Orthodontic Criteria for Medical Necessity Form
- Referral Evaluation for Comprehensive Orthodontic Treatment
- Continuation of Care Submission Form
- OrthoCAD Submission Form
- Direct Deposit/EFT Form
- W-9
- Standard Updates Form
- Non-Covered Service Disclosure Form
- Humana Member Appeal Consent Form

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service at 1-888-308-9345.

You can also scroll down to find these forms included in this document.

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 judgement, necessary or appropriate in my care.

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

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

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

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

Date: _____

Procedure(s): _____

_____

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.

MEDICAL AND DENTAL HISTORY FORM

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_____

Indicate which of the following you have had or have at present. Circle "Yes" or "No" for each item.

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

Are you pregnant? _ Yes _ No
If yes, what month? _____

Are you nursing? _ Yes _ No

Are you taking birth control pills? _ Yes _ No

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

Patient Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Review Date	Change in Health Status	Patient's Signature	Provider's Signature

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

Request for Transfer of Records

I, _____, hereby request and give my permission to

Dr. _____ to provide Dr. _____ any and all

information regarding past dental care for _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history,

consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

_____

_____

_____

Signed: _____   Date: _____

(Patient)

Signed: _____   Date: _____

(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: _____

_____

Phone: _____

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

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.

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.

DENTAL CLAIM FORM

ADA. Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   - [ ] Statement of Actual Services – OR – [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

Please send completed claim form to the dental claim address listed on your plan identification card.

PRIMARY PAYER INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical Coverage?   [ ] No (Skip 5-11)   [ ] Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

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

13. Date of Birth (MM/DD/CCYY)
14. Gender [ ] M [ ] F
15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status [ ] FTS [ ] PTS

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

21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F
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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent: 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

Primary: A B C D E F G H I J / T S R Q P O N M L K

32. Other Fee(s)

33. 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. Provider ID
50. License Number
51. SSN or TIN

52. Phone Number (   )   –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] 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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist)   Date

54. Provider ID
55. License Number

56. Address, City, State, Zip Code

57. Phone Number (   )   –
58. Treating Provider Specialty

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Instructions to the Dentist: X-rays may be required and should accompany the completed claim form for certain procedures. Please verify requirements according to the patient's specific plan. Please do not send originals. These will be reviewed and returned to your office.

General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.
a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

1.   EPSDT / Title XIX -- Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21.
2.   Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
4-11. Leave blank if no other coverage.
8.   The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
15. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
16. Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
19-23. Complete only if the patient is not the Primary Subscriber. (i.e., "Self" not checked in Item 18)
19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
23. Enter if dentist's office assigns a unique number to identify the patient that is not the same as the Subscriber Identifier number assigned by the payer (e.g., Chart #).
25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
26. Enter applicable ANSI ASC X12 code list qualifier: Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.
27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B = Buccal; D = Distal; F = Facial; L = Lingual; M = Mesial; and O = Occlusal.
29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature.*
31. Dentist's full fee for the dental procedure reported.
32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
33. Total of all fees listed on the claim form.
34. Report missing teeth on each claim submission.
35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
37. Subscriber Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
38. ECF is the acronym for Extended Care Facility (e.g., nursing home).
48-52. Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.
48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim
50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer.
     When the payment is being accepted directly report the: 1) SSN if the billing dentist in unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
56. Full address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: http://www.wpc-edi.com/codes/codes.asp. The available taxonomy codes, as of the first printing of this claim form, follow printed in **boldface**.

122300000X 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.

Many dentists are general practitioners who handle a wide variety of dental needs.
1223G0001X   General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:
1223D0001X Dental Public Health
1223E0200X Endodontics
1223P0106X Oral & Maxillofacial Pathology
1223D0008X Oral and Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics
1223P0221X Pediatric Dentistry (Pedodontics)
1223P0300X Periodontics
1223P0700X Prosthodontics

Comprehensive Orthodontics

Coverage of comprehensive orthodontics is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient. Orthodontic service is medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Purely cosmetic orthodontic service is not covered. Coverage is further limited to children under age 21. Only one course of orthodontic treatment per recipient, per lifetime is covered.

Prior authorization is required for all comprehensive orthodontic treatment. The following must be included with the prior authorization request:

1) **A completed 2006 or newer ADA claim form**
2) **Lateral and frontal photographs of the patient with lips together (D0471)**
3) **Cephalometric film with lips together, including a tracing (D0340)**
4) **A complete series of radiographs or a panoramic radiograph (D0210 or D0330)**
5) **Diagnostic models (D0470)**
6) **Treatment Plan, including projected length and cost of treatment**
7) **Completed Referral Evaluation Criteria Form (ODHS 3630)**

A patient must demonstrate a minimum of five (5) symptoms, with at least two (2) of the symptoms appearing under dentofacial abnormality before the provider considers submitting a request for consideration.

DentaQuest

Models ___
OrthoCAD ___
Lateral Ceph ___
X-Rays ___
Photos ___
Narrative ___

DentaQuest, LLC

OHIO ORTHODONTIC CRITERIA FOR MEDICAL NECESSITY

Patient Name: _____   **DOB:** _____

HealthPlan: _____   **Doctor Name:** _____

CRITERIA	YES	NO
Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
True anterior openbite (skeletal) involving 3 or more fully erupted teeth - viewed from a frontal view.		
Demonstrates a large anterior –posterior discrepancy. Class II and Class III malocclusions that are virtually a full tooth (greater than full step) Class II or Class III.		
Anterior crossbite of 3 or more teeth in the same arch		
Posterior transverse discrepancies. (Involves 3 or more maxillary posterior teeth in crossbite, one of which must be a molar).		
Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
Impacted anteriors that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where canines are going to erupt ectopically).		
Congenital, Developmental, or Traumatic Deformity with significant accompanying dental deformity.		
Documented Psychological, Speech, or Eating disorders that would be ameliorated by orthodontia. Documented from professionals within their scope of practice.		

Ohio Department of Medicaid
REFERRAL EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Individual	Provider
Name	Name
Medicaid ID number	Medicaid provider number
Date of birth	NPI

Mark all symptoms and indications that you observe in this patient.

Dentofacial Abnormality

- ☐ Marked protrusion of upper jaw and teeth
- ☐ Underdevelopment of lower jaw and teeth, receding chin
- ☐ Excessive spacing of front teeth
- ☐ Protrusion of upper or lower teeth such that lips cannot be brought together without strain
- ☐ Marked protrusion of lower jaw and teeth
- ☐ Marked crookedness, crowding, irregularity, or overlapping of teeth
- ☐ Marked asymmetry of lower face or transverse deficiency
- ☐ Cleft of lip or palate
- ☐ Abnormality of dental development
- ☐ Condition that increases likelihood of injury to teeth
- ☐ Condition that complicates or exacerbates TMJ dysfunction or another medical problem
- ☐ Other (Explain on the reverse side of the page.)

Tissue Damage Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked recession of gums
- ☐ Loosening of permanent teeth
- ☐ Other (Explain on the reverse side of the page.)

Mastication Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked grimacing or motions of the oral-facial muscles when swallowing or difficulty in swallowing
- ☐ Socially unacceptable eating behavior caused by necessary compensation for anatomic facial deviations
- ☐ Pain when eating
- ☐ Other (Explain on the reverse side of the page.)

Respiration or Speech Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Postural abnormalities with associated breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth-breathing
- ☐ Lisping, articulation errors, or other speech impairment
- ☐ History of or recommendation for speech therapy
- ☐ Other (Explain on the reverse side of the page.)

Adverse Psychosocial Impact Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ (Explain on the reverse side of the page. Supporting statements may be attached from professionals, the patient, or the patient's family concerning the adverse impact on self-image, social interaction, or other psychological or social aspect of life.)

Signature	Date

ODM 03630 (Rev. 1/2016)

DentaQuest.

Continuation of Care Submission Form

Date: _____

Patient Information

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

Provider Information

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

Name of Previous Vendor that issued original approval: [_____]

Banding Date: [_____] **Case Rate Approved By Previous Vendor:** [_____]

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

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

Balance Expected for Future Dates of Service: [_____]

Remaining services and quantities to be paid from prior approval: [_____]

Additional information required:

> **If approved through a prior Medicaid vendor, please submit the following:**
> - A complete Orthodontic Continuation of care form
> - A completed 2006 or greater ADA claim form listing the services to be rendered
> - A copy of the member's prior approval letter including the total approved case fee and payment structure
> - Detailed payment history
>
> **If approved through a private arrangement or commercial plan also include:**
> - A copy of the original study models or a complete set of diagnostic photographs prior to the patient being banded
> - Panorex film

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

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:

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

*Indicates Required Field. Please print legibly.

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	

Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	

Provider Identifiers Information			
*Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits		*National Provider Identifier (NPI) Numeric 10 Digits	

Provider Contact Information			
*Provider Contact Name- (Name of contact in provider office authorized to handle EFT issues		Title	
*Telephone Number		*Email Address	

Financial Institution Information	
*Financial Institution Name	

Financial Institution Address				
*Street		*City		
*State/Province		*Zip Code/Postal Code		
*ZIP Code/Postal Code		Financial Institution Telephone Number		
*Financial Institution Routing Number (Numeric 9 Digits)		*Type of Account at Financial Institution (e.g., Checking, Saving)		
*Provider's Account Number with Financial Institution		*Account Number Linkage to Provider Identifier – Select One	Provider TIN ☐ Provider NPI ☐	

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

DentaQuest

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

This authorization will remain in effect until revoked by me in writing. I agree **DentaQuest, LLC** 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 **DentaQuest, LLC's** treatment of each such credit entry, and the 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, **DentaQuest, LLC** shall be under no liability whatsoever.

Submission Date

Requested EFT Start/Change/Cancel Date

Authorized Signature

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

APPENDIX
Additional Information to assist with completion of this EFT/ACH Enrollment Form and the EFT/ACH banking process.

Please note the following *IMPORTANT* information:

- We are required to inform you that you MUST contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.

- **You MUST attach a voided check from your account.**

ACCOUNT HOLDER INFORMATION:

Personal Checking Example

Routing Number   Account Number   Check Number

Business Checking Example

Check Number   Routing Number   Account Number

Questions?
You may send your completed form, as well as any questions regarding the status of your EFT enrollment, to the fax number or email address provided below:

Fax: (262)241-4077
Email: StandardUpdates@dentaquest.com

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Form W-9

(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC   ☐ C Corporation   ☐ S Corporation   ☐ Partnership   ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

6 City, state, and ZIP code

Requester's name and address (optional)

7 List account number(s) here (optional)

Part I — Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II — Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and

3. I am a U.S. citizen or other U.S. person (defined below); and

4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here

Signature of U.S. person ▶ _____ Date ▶ _____

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid)

• Form 1099-DIV (dividends, including those from stocks or mutual funds)

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)

• Form 1099-S (proceeds from real estate transactions)

• Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Cat. No. 10231X   Form **W-9** (Rev. 10-2018)

Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@greatdentalplans.com or by fax to 262-241-4077

Section 1: Current Information - *Complete for ALL Requests - Asterisk denotes required fields*

*Effective Date *(If different than current date)* :	

*Provider Last Name		*Provider First Name	
*Individual National Provider Identifier (NPI) #			
Date of Birth		Social Security #	Gender
*Specialty		*Personal E-Mail	

Requestor Information

*Requestor Name		*Title	
*Requestor Contact Information *(Phone or E-mail)*			

Section 2: Type of Update - Check all that Apply - *Complete for ALL Requests* - For Questions contact your Provider Engagement Representative or Customer Service

- ☐ Business (Tax ID) - Add/ Term/ Update - Complete Sections 1, 6, 7 and 8
- ☐ Credentialing Correspondence Change/Update - Complete Sections 1 and 5
- ☐ EFT/ Payment - Complete Sections 1 and 8
- ☐ License Change - Complete Sections 1 and 4
- ☐ Name Change - Complete Sections 1 and 3
- ☐ Location - Add/ Term/ Update - Complete Sections 1 and 6
- ☐ Termination Request - Complete Sections 1 and 9

Section 3: Name Change - *Attach supporting legal documentation*

New Last Name		New First Name	
New Middle Name		New Suffix	

Please Note: Before your name can changed in our system, your license must reflect the name change.

Section 4: License Change

New Dental License Number		State	
New DEA License Number		State	
New State Drug License Number		State	
New Medicaid License Number		State	
Other License Name			
Other License Number		State	

Section 5: Credentialing Correspondence Change

Credentialing Contact Name					
Correspondence Address					
City		State		Zip Code	
Telephone		Fax			
Credentialing E-Mail					

Provider Update Form - Provider Operations

Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.

☐ Add	☐ Term	☐ Update

Tax ID Number [_____] Medicaid ID (if applicable) [_____]

Location Name [_____]

Location Address [_____]

City [_____] State [_____] Zip Code [_____]

Is this location a Mobile Dental Unit? ☐ Yes ☐ No

Telephone [_____] Fax [_____]

Can this fax number accept PHI? ☐ Yes ☐ No

Office E-Mail [_____]

Office Hours Monday - [_____] Tuesday - [_____]

Wednesday - [_____] Thursday - [_____]

Friday - [_____] Saturday - [_____]

Sunday - [_____] Ages Minimum [____] Ages Maximum [____]

☐ Primary Location ☐ Handicapped Accessible

Office Languages [_____]

Office URL [_____]

Section 7: Business - (Tax ID) Add/ Term/ Update - *Updated Contract, W9 and Disclosure of Ownership required for all Adds and Updates - W9 and Disclosure of Ownership Attached*

☐ Add	☐ Term	☐ Update

Old/ Current Tax ID Number [_____] New Tax ID Number [_____]

Business Name [_____]

Business Address [_____]

City [_____] State [_____] Zip Code [_____]

Telephone [_____] Fax [_____]

Office E-Mail [_____]

Group NPI [_____]

Please Note: A Group NPI is required for all business types except Sole Proprietors.

Will you have any outstanding claims to submit under the old/current Tax ID Number?
If yes, please provide a date of when all claims will be submitted by: [_____] ☐ Yes ☐ No

Section 8: EFT/ Payment

Tax ID Number [_____]

Payment Address [_____]

City [_____] State [_____] Zip Code [_____]

☐ Add EFT	☐ Cancel EFT	☐ Change EFT

Please Note: The EFT Form will need to be completed for any Adds or Updates. This includes a copy of a voided check or a bank letter (attached)

Provider Update Form - Provider Operations

Section 9: Termination Request

☐	Term Provider at Location Listed Below	Tax ID Number	

Please attach document with any additional locations to be termed.

☐	Term Provider at ALL Locations - ALL Networks

Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.

☐	Term Business	Tax ID Number	

Please attach a list of providers and locations that need to be terminated.

Term Reason/ Comments

Location Name

Location Address

City   State   Zip Code

Notes

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

Appendix B

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations for Members younger than 21. Providers with benefit questions should call DentaQuest Customer Service directly at: 855-208-6575, press option two.

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

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

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

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

American Dental Association
211 East Chicago Ave. Chicago, IL 60611
800-947-4746

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

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

1. The ADA approved service code to submit when billing,

2. Brief description of the covered service,

3. Any age limits imposed on coverage,

4. A description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,

5. An indicator of whether the service is subject to prior authorization, any other applicable benefit limitations.

IMPORTANT INFORMATION – DOCUMENTATION SUBMISSION GUIDELINES

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 to submit documentation if an authorization is required:

"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 should be submitted with the claim (authorization not required):

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
No	Documentation Requested	Non-emergency (Routine) or Emergency	Send documentation with claim after treatment

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the Member's oral health. Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not, in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations. All radiographs must be of diagnostic quality, properly mounted, dated and identified with the Member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 4 Month(s) Per patient. One of (D0120, D0150) per 4 Month(s) Per Provider.	
D0140	limited oral evaluation-problem focused	21 and older		No		
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 60 Month(s) Per Provider OR Location. One of (D0120, D0150) per 4 Month(s) Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 1 Year(s) Per patient. Not reimbursable on the same day as a D0120 and D0150.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	21 and older		No		
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No		
D0270	bitewing - single radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0273	bitewings - three radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0321	other temporomandibular joint films, by report	21 and older		Yes		
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0340	cephalometric radiographic image	21 and older		No	One of (D0340) per 12 Month(s) Per Provider OR Location.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	21 and older		No	One of (D0350) per 12 Month(s) Per Provider OR Location.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	21 and older		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No		
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	21 and older		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	

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Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	21 and older		No	One of (D0220, D0374) per 12 Month(s) Per patient.	
D0396	3D printing of a 3D dental surface scan	21 and older		No	One of (D0396) per 1 Day(s) Per Provider. This service is included in another benefit.	
D0470	diagnostic casts	21 and older		No	One of (D0470) per 12 Month(s) Per Provider OR Location.	
D0604	antigen testing for a public health related pathogen, including coronavirus	21 and older		No		
D0605	antibody testing for a public health related pathogen, including coronavirus	21 and older		No		
D0801	3D dental surface scan – direct	21 and older		Yes	One of (D0801) per 1 Day(s) Per patient. Two of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0802	3D dental surface scan – indirect	21 and older		Yes	One of (D0802) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0803	3D facial surface scan – direct	21 and older		Yes	One of (D0803) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0804	3D facial surface scan – indirect	21 and older		Yes	One of (D0804) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	

Space maintainers are a covered service when medically indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not permature loss of the primary molar is considered a transitional orthodontic appliance and not covered by this Plan.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4346) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1206, D1208) per 96 Month(s) Per patient.	
D1301	immunization counseling	21 and older		No	One of (D1301) per 12 Month(s) Per patient.	
D1320	tobacco counseling for control and prevention of oral disease	21 and older		No	Two of (D1320) per 12 Month(s) Per patient.	
D1321	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	21 and older		No	Two of (D1321) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1354) per 1 Day(s) Per patient per tooth. Three of (D1354) per 1 Year(s) Per patient per tooth.	
D1355	caries preventive medicament application – per tooth	21 and older	Teeth 1 - 32, A - T	No	Maximum four teeth per date of service.	
D1510	space maintainer-fixed, unilateral- per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1516	space maintainer --fixed--bilateral, maxillary	21 and older		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1517	space maintainer --fixed--bilateral, mandibular	21 and older		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1520	space maintainer-removable-unilateral	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim.	
D1526	space maintainer --removable--bilateral, maxillary	21 and older		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	21 and older		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

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. 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 and curing are included as part of the restoration. 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. 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.
BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE IMPRESSION DATE. DO NOT BILL UNTIL DELIVERED.

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

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

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		pre-operative x-ray(s)
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No		
D2928	prefabricated porcelain/ceramic crown – permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2928) per 60 Month(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	21 and older	Teeth C - H, M - R	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	21 and older	Teeth A - T	No		
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No		

	Restorative					
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2933	prefabricated stainless steel crown with resin window	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	21 and older	Teeth A - T	No		
D2940	Placement of interim direct restoration.	21 and older	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950) per 60 Month(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	Yes	Three of (D2951) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D2952	cast post and core in addition to crown	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2952) per 1 Day(s) Per patient per tooth.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2956	removal of an indirect restoration on a natural tooth	21 and older	Teeth 1 - 32	Yes	One of (D2956) per 1 Lifetime Per patient per tooth. Must have existing defective crown in place.	narr. of med. necessity, pre-op x-ray(s)
D2976	band stabilization – per tooth	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2976) per 1 Lifetime Per patient. This service is included in another benefit.	
D2989	excavation of a tooth resulting in the determination of non-restorability	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2989) per 1 Lifetime Per patient.	
D2991	application of hydroxyapatite regeneration medicament – per tooth	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2991) per 1 Lifetime Per patient.	

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Reimbursement includes local anesthesia. In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4286	removal of non-resorbable barrier	21 and older		Yes	Four of (D4286) per 1 Day(s) Per patient. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	21 and older		No	Two of (D1110, D4346) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		No	One of (D4910) per 12 Month(s) Per patient.	

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem. A preformed denture with teeth already mounted forming a denture module is not a covered service. Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars). Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICSSHALL BE BASED ON THE CEMENTATION DATE.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	One of (D5212, D5214, D5226) per 96 Month(s) 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)	21 and older		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5212, D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	21 and older		Yes	One of (D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	21 and older		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture - per tooth	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace missing or broken teeth – partial denture – per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture – per tooth	21 and older	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No		
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5750) per 36 Month(s) Per patient. One of (D5750) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of(D5130, D5140)	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5751) per 36 Month(s) Per patient. One of (D5751) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	One of (D5760) per 36 Month(s) Per patient. One of (D5760) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	One of (D5761) per 36 Month(s) Per patient. One of (D5761) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5899	unspecified removable prosthodontic procedure, by report	21 and older		Yes		

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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

Implant Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6089	accessing and retorquing loose implant screw – per screw	21 and older	Teeth 1 - 32	No	One of (D6089) per 60 Month(s) Per patient per tooth. This service is included in another benefit.	
D6096	remove broken implant retaining screw	21 and older	Teeth 1 - 32	Yes		narrative of medical necessity
D6105	removal of implant body not requiring bone removal nor flap elevation	21 and older	Teeth 1 - 32	Yes	One of (D6105) per 1 Day(s) Per patient per tooth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D6106	guided tissue regeneration – resorbable barrier, per implant	21 and older	Teeth 1 - 32	Yes	One of (D6106, D6107, D7956, D7957) per 60 Month(s) Per patient per tooth.	Full mouth x-rays
D6107	guided tissue regeneration – non-resorbable barrier, per implant	21 and older	Teeth 1 - 32	Yes	One of (D6106, D6107, D7956, D7957) per 60 Month(s) Per patient per tooth.	Full mouth x-rays
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	21 and older	Teeth 1 - 32	No	One of (D6180) per 6 Month(s) Per patient per tooth.	
D6193	replacement of an implant screw	21 and older	Teeth 1 - 32	No	One of (D6193) per 1 Lifetime Per patient per tooth. Must have implant in place on same tooth.	
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	21 and older	Teeth 1 - 32	Yes	One of (D6197) per 24 Month(s) Per patient per tooth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Reimbursement includes local anesthesia and routine post-operative care. 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. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7220) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D7241) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7250) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7259	nerve dissection	21 and older	Teeth 1 - 32	Yes	Only allowed with removal of impacted tooth.	narr. of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	Yes		
D7284	excisional biopsy of minor salivary glands	21 and older		No	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	Pathology report
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7321) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D7471) per 1 Lifetime Per patient per arch.	pre-operative x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7472	removal of torus palatinus	21 and older		Yes	One of (D7472) per 1 Lifetime Per patient.	pre-operative x-ray(s)
D7473	removal of torus mandibularis	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7473) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7509	marsupialization of odontogenic cyst	21 and older	Teeth 1 - 32, A - T	Yes	One of (D7509) per 1 Lifetime Per patient per tooth for All Permanent Teeth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		Yes		narr. of med. necessity, post-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	21 and older		Yes		narr. of med. necessity, post-op x-ray(s)
D7899	unspecified TMD therapy, by report	21 and older		Yes		pre-operative x-ray(s)
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	21 and older	Teeth 1 - 32	Yes	One of (D7956) per 1 Lifetime Per patient per tooth.	narrative of medical necessity
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	21 and older	Teeth 1 - 32	Yes	One of (D7957) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7962	lingual frenectomy (frenulectomy)	21 and older		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7979	non-surgical sialolithotomy	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	21 and older		Yes		narrative of medical necessity

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9130	temporomandibular joint dysfunction--non-invasive physical therapies	21 and older		No		narrative of medical necessity
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Four of (D9223) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	One of (D9222, D9223, D9239, D9243) per 1 Day(s) Per patient.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Four of (D9243) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9610	therapeutic drug injection, by report	21 and older		No	Three of (D9610, D9612) per 1 Day(s) Per patient.	
D9612	therapeutic drug injection - 2 or more medications by report	21 and older		No	Three of (D9610, D9612) per 1 Day(s) Per patient.	
D9613	infiltration of sustained release therapeutic drug--per quadrant	21 and older		Yes		narrative of medical necessity
D9920	behavior management, by report	21 and older		No		
D9944	occlusal guard--hard appliance, full arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9945	occlusal guard--soft appliance full arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9946	occlusal guard--hard appliance, partial arch	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	

Exhibit A Benefits Covered for
OH AmeriHealth Adult and ABD

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9947	custom sleep apnea appliance fabrication and placement	21 and older	Per Arch (01, 02, LA, UA)	Yes		
D9948	adjustment of custom sleep apnea appliance	21 and older	Per Arch (01, 02, LA, UA)	Yes		
D9949	repair of custom sleep apnea appliance	21 and older	Per Arch (01, 02, LA, UA)	Yes		
D9953	Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.	21 and older		Yes		
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	21 and older		No	One of (D9954, D9955) per 24 Month(s) Per patient.	
D9955	oral appliance therapy (OAT) titration visit	21 and older		No	Two of (D9954, D9955) per 12 Month(s) Per patient.	
D9961	duplicate/copy patient's records	21 and older		Yes		narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with D0140 or D0120.	
D9997	Dental case management - patients with special health care needs	21 and older		Yes		narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the Member's oral health. Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not, in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations. All radiographs must be of diagnostic quality, properly mounted, dated and identified with the Member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per Provider.	
D0140	limited oral evaluation-problem focused	0-20		No		
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 60 Month(s) Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	One of (D0180) per 1 Year(s) Per patient. Not covered on same date of service as D0120 or D0150	
D0210	intraoral - comprehensive series of radiographic images	0-20		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No		
D0270	bitewing - single radiographic image	0-20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	

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			Diagnostic			
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0273	bitewings - three radiographic images	10 - 20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0321	other temporomandibular joint films, by report	0-20		No		
D0330	panoramic radiographic image	0-20		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0340	cephalometric radiographic image	0-20		No	One of (D0340) per 12 Month(s) Per Provider OR Location.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	One of (D0350) per 12 Month(s) Per Provider OR Location.	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-20		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-20		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-20		No		
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-20		No	One of (D0210, D0330, D0367, D0372, D0387) per 60 Month(s) Per Provider OR Location.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-20		No	One of (D0270, D0272, D0273, D0274, D0373, D0388) per 6 Month(s) Per Provider OR Location.	

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Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-20		No	One of (D0220, D0374) per 12 Month(s) Per patient.	
D0396	3D printing of a 3D dental surface scan	0-20		No	One of (D0396) per 1 Day(s) Per Provider. This service is included in another benefit.	
D0470	diagnostic casts	0-20		No	One of (D0470) per 12 Month(s) Per Provider OR Location.	
D0604	antigen testing for a public health related pathogen, including coronavirus	0-20		No		
D0605	antibody testing for a public health related pathogen, including coronavirus	0-20		No		
D0801	3D dental surface scan – direct	0-20		Yes	One of (D0801) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0802	3D dental surface scan – indirect	0-20		Yes	One of (D0802) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0803	3D facial surface scan – direct	0-20		Yes	One of (D0803) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	
D0804	3D facial surface scan – indirect	0-20		Yes	One of (D0804) per 1 Day(s) Per patient. One of (D0470, D0801, D0802, D0803, D0804) per 36 Month(s) Per patient.	

Space maintainers are a covered service when medically indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not permature loss of the primary molar is considered a transitional orthodontic appliance and not covered by this Plan.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	14 - 20		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1120	prophylaxis - child	0-13		No	One of (D1110, D1120) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1301	immunization counseling	0-20		No	One of (D1301) per 12 Month(s) Per patient.	
D1320	tobacco counseling for control and prevention of oral disease	0-20		No	Two of (D1320) per 12 Month(s) Per patient.	
D1321	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	0-20		No	Two of (D1321) per 12 Month(s) Per patient.	
D1351	sealant - per tooth	5 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No		
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D1354) per 1 Day(s) Per patient per tooth. Three of (D1354) per 1 Year(s) Per patient per tooth. Pit and fissure sealant may be applied to previously unrestored areas of permanent first and second molarS.	
D1355	caries preventive medicament application – per tooth	0-20	Teeth 1 - 32, A - T	No	One of (D1355) per 1 Day(s) Per patient per tooth. Four of (D1355) per 1 Day(s) Per patient. Maximum four teeth per date of service.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1516, D1526) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1517, D1527) per 24 Month(s) Per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim.	

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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. 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 and curing are included as part of the restoration. 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. 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. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE IMPRESSION DATE. DO NOT BILL UNTIL DELIVERED.

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2140	Amalgam - one surface, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2150	Amalgam - two surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)

Exhibit B Benefits Covered for
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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2160	amalgam - three surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2330	resin-based composite - one surface, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2335	resin-based composite - four or more surfaces (anterior)	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2391	resin-based composite - one surface, posterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2392	resin-based composite - two surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

Exhibit B Benefits Covered for
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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2393	resin-based composite - three surfaces, posterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	5 - 20	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	10 - 20	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2751, D2752, D2794) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No		
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 1 - 32	No	One of (D2928) per 60 Month(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth C - H, M - R	No	One of (D2929) per 60 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-4	Teeth D - G, N - Q	No		
D2930	prefabricated stainless steel crown - primary tooth	0-9	Teeth A - C, H - M, R - T	No		
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth 1 - 32	No		
D2930	prefabricated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	No		pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	No		pre-operative x-ray(s)
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	No		
D2933	prefabricated stainless steel crown with resin window	0-4	Teeth D - G, N - Q	No		
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth 1 - 32	No		
D2933	prefabricated stainless steel crown with resin window	5 - 20	Teeth D - G, N - Q	No		pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-9	Teeth A - C, H - M, R - T	No		
D2933	prefabricated stainless steel crown with resin window	10 - 20	Teeth A - C, H - M, R - T	No		pre-operative x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth 1 - 32	No		
D2940	Placement of interim direct restoration.	0-20	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	Yes	Three of (D2951) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D2952	cast post and core in addition to crown	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2952) per 1 Day(s) Per patient per tooth.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2956	removal of an indirect restoration on a natural tooth	0-20	Teeth 1 - 32, A - T	Yes	One of (D2956) per 1 Lifetime Per patient per tooth. Must have existing defective crown in place.	narr. of med. necessity, pre-op x-ray(s)
D2976	band stabilization – per tooth	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2976) per 1 Lifetime Per patient per tooth. This service is included in another benefit.	
D2989	excavation of a tooth resulting in the determination of non-restorability	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2989) per 1 Lifetime Per patient per tooth.	
D2991	application of hydroxyapatite regeneration medicament – per tooth	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D2991) per 1 Lifetime Per patient per tooth.	

Reimbursement includes local anesthesia. In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Covered to correct severe hyperplastic or hypertropic gingivititis associated with drug therapy or hormonal disturbances.	pre-operative x-ray(s)
D4286	removal of non-resorbable barrier	0-20		Yes	Four of (D4286) per 1 Day(s) Per patient. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4910	periodontal maintenance procedures	0-20		No	One of (D4910) per 12 Month(s) Per patient.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem. A preformed denture with teeth already mounted forming a denture module is not a covered service. Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars). Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation. BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICSSHALL BE BASED ON THE CEMENTATION DATE.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-20		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	0-20		Yes	One of (D5110, D5130) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	0-20		Yes	One of (D5120, D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5212, D5214, D5226) per 96 Month(s) 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)	0-20		Yes	One of (D5211, D5213, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 96 Month(s) Per patient.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 96 Month(s) Per patient.	pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5511	repair broken complete denture base, mandibular	0-20		No		
D5512	repair broken complete denture base, maxillary	0-20		No		
D5520	replace missing or broken teeth - complete denture - per tooth	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	0-20		No		
D5622	repair cast partial framework, maxillary	0-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace missing or broken teeth – partial denture – per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture – per tooth	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No		
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 36 Month(s) Per patient. One of (D5750) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of(D5130, D5140)	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 36 Month(s) Per patient. One of (D5751) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 36 Month(s) Per patient. One of (D5760) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 36 Month(s) Per patient. One of (D5761) per 36 months of placement of (D5110, D5120, D5130, D5140). Not separately reimbursable within 6 months of placement of (D5130, D5140)	
D5899	unspecified removable prosthodontic procedure, by report	0-20		Yes		

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

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

Implant Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6089	accessing and retorquing loose implant screw – per screw	0-20	Teeth 1 - 32	No	One of (D6089) per 60 Month(s) Per patient per tooth. This service is included in another benefit.	
D6096	remove broken implant retaining screw	0-20	Teeth 1 - 32	Yes		narrative of medical necessity
D6105	removal of implant body not requiring bone removal nor flap elevation	0-20	Teeth 1 - 32	Yes	One of (D6105) per 1 Day(s) Per patient per tooth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D6106	guided tissue regeneration – resorbable barrier, per implant	0-20	Teeth 1 - 32	Yes	One of (D6106, D6107, D7956, D7957) per 60 Month(s) Per patient per tooth.	Full mouth x-rays
D6107	guided tissue regeneration – non-resorbable barrier, per implant	0-20	Teeth 1 - 32	Yes	One of (D6106, D6107, D7956, D7957) per 60 Month(s) Per patient per tooth.	Full mouth x-rays
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	0-20	Teeth 1 - 32, A - T	No	One of (D6180) per 6 Month(s) Per patient per tooth.	
D6193	replacement of an implant screw	0-20	Teeth 1 - 32, A - T	No	One of (D6193) per 1 Lifetime Per patient per tooth. Must have implant in place on same tooth.	
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-20	Teeth 1 - 32	Yes	One of (D6197) per 24 Month(s) Per patient per tooth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for
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Reimbursement includes local anesthesia and routine post-operative care. 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. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-5	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6-10	Teeth A - C, H - M, R - T	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth D - G, N - Q	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	11 - 20	Teeth A - C, H - M, R - T	No	One of (D7210) per 1 Lifetime Per patient per tooth.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7220) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7230) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7240) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D7241) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7250) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D7259	nerve dissection	0-20	Teeth 1 - 32, A - T	Yes	Only allowed with removal of impacted tooth.	narr. of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, post-op x-ray(s)
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7284	excisional biopsy of minor salivary glands	0-20		No	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		Yes	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	Pathology report
D7286	incisional biopsy of oral tissue-soft	0-20		Yes	One of (D7284, D7285, D7286) per 1 Day(s) Per patient per tooth.	Pathology report
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D7471) per 1 Lifetime Per patient per arch.	pre-operative x-ray(s)
D7472	removal of torus palatinus	0-20		Yes	One of (D7472) per 1 Lifetime Per patient.	pre-operative x-ray(s)
D7473	removal of torus mandibularis	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7473) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7509	marsupialization of odontogenic cyst	0-20	Teeth 1 - 32, A - T	Yes	One of (D7509) per 1 Lifetime Per patient per tooth for All Permanent Teeth. Pre-Transplant or Emergency Services Only.	narr. of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes		narr. of med. necessity, post-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes		narr. of med. necessity, post-op x-ray(s)
D7899	unspecified TMD therapy, by report	0-20		Yes		pre-operative x-ray(s)

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	0-20	Teeth 1 - 32	Yes	One of (D7956) per 1 Lifetime Per patient per tooth.	narrative of medical necessity
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	0-20	Teeth 1 - 32	Yes	One of (D7957) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes		narrative of medical necessity
D7962	lingual frenectomy (frenulectomy)	0-20		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7979	non-surgical sialolithotomy	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

Coverage of comprehensive orthodontics is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient. Orthodontic service is considered to be medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Purely cosmetic orthodontic service is not covered. Coverage is further limited to children under age 21. Only one course of orthodontic treatment per recipient, per lifetime is covered.

D8670 periodic orthodontic treatment visit 21 and older would only be covered for a member whose comprehensive treatment had begun prior to age 21. One per 90 Day(s) Per patient. Allowed as quarterly treatment visit. (D8670). May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090. Only payable to a dental provider with a specialty of Orthodontics. Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

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

The ODMS 3630 Referral Evaluation Criteria Form is used as the basis for determining whether a Member qualifies for orthodontic treatment. Completed ODMS 3630 form and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member or face possible termination of their Provider agreement. Providers cannot bill prior to services being performed.

If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. DentaQuest will provide payment to the provider for the procedures submitted when requested (i.e. D0330, D0340, D0350, D0470).

General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on this date of service. If a Member becomes ineligible during treatment and before full payment is made, it is the Member's responsibility to pay the balance for any remaining treatment. The Provider should notify the Member of this requirement prior to beginning treatment. To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

Electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is 262. 241.7150. Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit claims for periodic treatment visits (Code D8670) and 2 units of retention (D8680). The member must be eligible on the date of the visit.

The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 8 quarters of periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 8 quarters will be the Provider's financial responsibility and not the Member's. Members may not be billed for broken, repaired, or replacement of brackets or wires. The Member must be eligible with their Health Plan in order for payments to be made. Whenever the Member becomes ineligible, the Member is responsible for payment during that time period.

Please notify DentaQuest should the Member discontinue treatment for any reason

Continuation of Treatment:

DentaQuest of Ohio, LLC requires the following information for possible payment of continuation of care cases:

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* Completed 'Orthodontic Continuation of Care Form'

* Completed ADA claim form listing services to be rendered.

* A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.

* A copy of the patient billing ledger

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

					Orthodontics			
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient. Additional Documentation required: Ceph, Photos and Pano.	
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	One of (D8210) per 1 Lifetime Per patient. Complete images, diagnostic models, or photographs of the mouth. Additional Documentation.	narrative of medical necessity
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	Two of (D8220) per 1 Lifetime Per patient. Complete images, diagnostic models, or photographs of the mouth. Additional Documentation.	narrative of medical necessity
D8670	periodic orthodontic treatment visit	0-20		Yes	Seven of (D8670) per 1 Lifetime Per patient. One of (D8670) per 90 Day(s) Per patient.	
D8680	orthodontic retention (removal of appliances)	0-20		Yes	Two of (D8680) per 1 Lifetime Per patient per arch.	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-20		Yes		narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	0-20		Yes	Debanding only.	

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9130	temporomandibular joint dysfunction--non-invasive physical therapies	0-20		No		narrative of medical necessity
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Four of (D9223) per 1 Day(s) Per patient. Not allowed on same day as D9239, D9243	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	One of (D9222, D9223, D9239, D9243) per 1 Day(s) Per patient.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9222, D9239) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Four of (D9243) per 1 Day(s) Per patient. Not allowed on same date as (D9222, D9223).	
D9610	therapeutic drug injection, by report	0-20		No	Three of (D9610, D9612) per 1 Day(s) Per patient.	
D9612	therapeutic drug injection - 2 or more medications by report	0-20		No	Three of (D9610, D9612) per 1 Day(s) Per patient.	
D9613	infiltration of sustained release therapeutic drug--per quadrant	0-20		Yes		narrative of medical necessity
D9920	behavior management, by report	0-20		No		
D9944	occlusal guard--hard appliance, full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	
D9946	occlusal guard--hard appliance, partial arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	

Exhibit B Benefits Covered for
OH AmeriHealth Medicaid Child, Child ABD, and CIC

			Adjunctive General Services			
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9947	custom sleep apnea appliance fabrication and placement	0-20	Per Arch (01, 02, LA, UA)	Yes		
D9948	adjustment of custom sleep apnea appliance	0-20	Per Arch (01, 02, LA, UA)	Yes		
D9949	repair of custom sleep apnea appliance	0-20	Per Arch (01, 02, LA, UA)	Yes		
D9953	Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.	0-20		Yes		
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	0-20		No	One of (D9954, D9955) per 24 Month(s) Per patient.	
D9955	oral appliance therapy (OAT) titration visit	0-20		No	Two of (D9954, D9955) per 12 Month(s) Per patient.	
D9961	duplicate/copy patient's records	0-20		No		narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Must be billed with D0140 or D0120..	
D9997	Dental case management - patients with special health care needs	0-20		Yes		narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	0-20		Yes		pre-operative x-ray(s)