TENNCARE ADULT ORAL HEALTH PROGRAMS OFFICE REFERENCE MANUAL

Tenncare Adult & Pregnancy/Postpartum Dental Program

Individuals with Intellectual & Developmental Disabilities (IDD) Programs

- EMPLOYMENT & COMMUNITY FIRST CHOICES (ECF CHOICES) program
- 1915(c) Home and Community Based Services Waivers

Managed by DentaQuest USA Insurance CO., LLC.

PO Box 2906
Milwaukee, WI 53201-2906
855-418-1623

The Office Reference Manual is subject to periodic updates; please ensure that you are using the latest version. The most current copy can be found online at www.dentaquest.com. Go to the Tennessee link and go to the provider resources tab to view.Each quarter you can find what sections received updates or changes in your provider newsletter.

Introduction

Addresses and Telephone Numbers

DentaQuest Customer Service
Member Services: 855.418.1622
Provider Services: 855.418.1623

PO Box 2906
Milwaukee, WI 53201-2906

Fax numbers:
Claims to be reprocessed: 262.834.3589

Claims Questions:
denclaims@dentaquest.com

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

TDD/TTY (Hearing Impaired)
800.466.7566

Special Needs Member Services
800.660.3397

TennCare Fraud Hotline
800.433.3982

Web Site
www.dentaquest.com

Credentialing
PO Box 2906
Milwaukee, WI 53201-2906

Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Outpatient/Hospital
Fax: 262.834.3575

Dental claims should be sent to:
DentaQuest – TennCare
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Direct entry on the web
www.dentaquest.com
Or, Via Clearinghouse – Payer ID CX014
Include address on electronic claims:
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

Provider Appeals
DentaQuest – TennCare Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.834.3452
Email: TennCareCGA@dentaquest.com

TennCare℠ Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
800.878.3192

Tagline & Notice Templates

Do you need free help with this letter? If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.
Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-418-1622 (TRS:711).
Kurdish: کوردی ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە **1-855-418-1622 (TRS:711)..**بکە
Arabic: ربيةلعا وظةملح: اذا متتكلةللغا ربيةلعا اتمدخدةعالمسا ويةللغا رةفومتكلانجام. اتصل مقبر:**1-855-418-1622** مقر فتاه **(TRS: 711)**صملا و ملبكا
Chinese: 繁體中文 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-418-1622 (TRS:711).
Vietnamese: Tiếng Việt CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-418-1622 (TRS:711).
Korean: 한국어 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-418-1622 (TRS:711).번으로 전화해 주십시오.
French: Français ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-418-1622 (TRS:711).
Amharic: አማርኛ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-8855-418-1622 (መስማት ለተሳናቸው:TRS:711).
Gujarati: ગજુ રાતી સચુ ના: જો તમે ગજુ રાતી બોલતા હો, તો નન:શલ્ુ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-418-1622 (TRS:711) .
Laotian: ພາສາລາວ ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເ ວົ້ າພາສາ ລາວ, ການໍບໍລການຊ່ ວຍເຫຼືອ ດ້ ານພາສາ, ໂດຍໍ່ບເສັ ຽຄ່ າ, ແມ່ ນມີພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-855-418-1622 (TRS:711).
German: Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-418-1622 (TRS:711).

Tagalog: Tagalog **PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-418-1622 (TRS:711).**

Hindi: हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-418- 1622 (TRS:711) . पर कॉल करें।**
Serbo-Croatian: Srpsko-hrvatski **OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.** **Nazovite 1-855-418-1622 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).**
Russian: Русский **ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.** **Звоните 1-855-418-1622 (телетайп: TRS:711).**
Nepali: नेपाली ध्यान हदनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईंको ननम्नत भाषा सहायता सेवा रू ननिःशुल्क रूपमा उपलब्ध छ । फोन गनुहोस् **1-855-418-1622 (हिहिवाई: TRS:711 ।**
Persian: فارسی **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با **1-855-418-1622 (TRS:711).** تماس بگیرید

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 855-418-1622. We can connect you with the free help or service you need. (For TRS call: 711)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birthplace, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

TennCare Office of Civil Rights Compliance 310 Great Circle Road, 3W Nashville, Tennessee 37243 Email: HCFA.Fairtreatment@tn.gov Phone: 855-857-1673 (TRS 711) You can get a complaint form online at: https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf	**MCO Information** DentaQuest PO Box 2906 Milwaukee, WI 53201-2906 855-418-1622	**U.S. Department of Health & Human Services Office for Civil Rights** 200 Independence Ave SW, Rm 509F, HHH Bldg Washington, DC 20201 Phone: 800-368-1019 (TDD): 800-537-7697 You can get a complaint form online at: http://www.hhs.gov/ocr/office/file/index.html Or you can file a complaint online at:

		https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Program Objectives (Adult Dental, Pregnancy and Postpartum Oral Health, Intellectual or Developmental Disabilities (IDD)/ Employment and Community First CHOICES (ECF CHOICES)

TennCare Adult Dental Program

The primary objective of the TennCare Adult Dental Program is to create a dental care system offering Covered Services that are Medically Necessary to eligible Adult Tennessee residents. We emphasize early intervention and promote access to necessary dental care, thereby improving health outcomes for Tennessee residents.

Short Term Goals

During the adult years, it is essential to provide patients with appropriate and timely oral health care, which includes oral health education and dental care. In the adult population, caries coupled with periodontal disease are the main causes of tooth loss. Oral health care is an important component of overall health, well being and quality of life. The control of disease progression is an immediate goal of the program.

Long Term Goals

This program is designed to benefit our member's overall health by focusing on, improving, and maintaining the health of the dentition, periodontium/ gingiva and oral cavity. **Maintaining a disease-free oral cavity reduces systemic disease complications.** Oral health education and nutritional education can help to establish good oral health hygiene habits and dietary habits that will benefit adults over the course of their lives while leading to improved oral and overall health. Finally, this program seeks to improve communication between healthcare professionals and establish dental professionals as critical touchstones in the healthcare continuum for this population.

We communicate with members to stress that preventive care is one of the best ways to achieve good oral and overall health. We emphasize this message with members and their caregivers. Members are provided information about available services and access to the services through the following:

- Provider directory
- Welcome packets
- Member Handbook

Pregnancy and Postpartum Oral Health

Pregnancy and Postpartum Oral Health care is an important component of adult dental care. Offering quality, medically necessary, covered services to eligible pregnant and postpartum Tennessee residents that results in long-term overall health of the member and their child is our objective. We emphasize early intervention and promote access to necessary dental care, thereby improving child

and maternal health outcomes for Tennessee residents because **oral health care is an important component of a healthy pregnancy.**

The pregnancy and postpartum component of the Adult Dental Program is specifically designated to provide additional attention to pregnant and postpartum Members. Pregnancy is a unique period during a woman's life and is characterized by complex physiological changes, which may adversely affect oral health and overall well-being. Preventive, diagnostic, and restorative **dental treatment is safe throughout pregnancy** and is effective in improving and maintaining oral and overall health.

Historically, routine oral health care has not always been offered to pregnant women; and often pregnant women, including some with obvious signs of oral disease, do not seek or receive care. However, failure to address infections in the oral cavity have been linked to poor birth outcomes and poor maternal outcomes. **The current standard of care is comprehensive oral health care for pregnant and postpartum women, and it is a safe and effective way to decrease adverse birth outcomes and maternal morbidity.**

Short Term Goals
During the pregnancy and postpartum period, it is essential to provide mothers with appropriate and timely health care, which includes oral health education and dental care. Oral health care is an important component of a healthy pregnancy and postpartum period. Elimination of pain, infection, irritation, and the restoration of health to the oral cavity is one of the main goals of dental care during this time.

Long Term Goals
This program is designed to benefit our members overall health and to improve birth outcomes by focusing on, improving, and maintaining the health of the dentition, gingiva and oral cavity. **Maintaining a disease free maternal oral cavity reduces vertical transmission and is the first positive step in achieving oral health in the newborn.** Oral health education and nutritional education can help to establish good oral health hygiene habits and dietary habits that will benefit both the mother and child over the course of their lives while leading to improved oral and overall health. Finally, this program component seeks to improve communication between healthcare professionals and establish dental professionals as critical touchstones in the healthcare continuum for this population.

IDD Programs (1915(c) Waiver & Employment and Community First CHOICES (ECF CHOICES)

The primary objective of the TennCare Employment and Community First CHOICES (ECF CHOICES) and the191(c)) Home and Community Based Services Waivers for Individuals with Intellectual or Developmental Disabilities Dental programs is to create an extensive dental care system offering covered services that are medically necessary to eligible Tennessee residents. Members of these programs are also covered under the TennCare Adult benefit. The IDD programs offer supplemental coverage for services not covered under the Adult benefit. We emphasize early intervention and promote access to necessary dental care, thereby improving health outcomes for Tennessee residents.

We communicate with members to stress that preventive care is one of the best ways to achieve

good oral and overall health. We emphasize this message with members and their parents/guardians. Members are provided information about available services and access to the services through the following:

- Provider directory
- Welcome packets
- Member Handbook

Residents of Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

TennCare Members residing in Nursing Facilities and ICFs/IID are now covered by the TennCare Adult Dental Benefit. DentaQuest is committed to facilitating the overall health and wellness of these residents through medically necessary oral health care.

Comprehensive dental care is just as important for facility residents as it is for adults living in the community. Unfortunately, many facility residents cannot easily travel to a dentist's office. Therefore, we are offering dental benefits through mobile dental units that bring dentists to the facility. Most routine dental care can be provided by mobile dentists.

We communicate with members to stress that preventive care is one of the best ways to achieve good oral and overall health. We emphasize this message with members and their families. Members in these facilities will be receiving information about covered services from DentaQuest.

Dentists serving residents of NF and ICFs/IID are now required to become contracted providers with DentaQuest in order to treat patients in these facilities.

All claims and preauthorization requests for NF and ICF/IID residents will be submitted to DentaQuest who will review cases for medical necessity and make service determinations under the TennCare Adult Dental Benefit.

Services that were formerly provided by out of network dentists and paid for by the enrollees as Incurred Medical Expenses (IME) will now, for the most part, be covered by TennCare's Adult Dental benefit. You should assume the services you want to deliver will be covered by the Adult Dental Benefit. Therefore, all service requests will need to go through DentaQuest to determine coverage. Only services that are not covered by the Adult Dental Benefit will still count as IME. Services that are considered to be IME will continue to be handled by TennCare's Member Services team.

Covered Services and Medical Necessity

DentaQuest is responsible for administering the TennCare Dental Programs and covered dental benefits as medically necessary for TennCare Members who are eligible for the dental programs. A list of the Covered Service codes can be found in Exhibit B of this manual. DentaQuest must provide coverage in a manner that satisfies all regulatory rules and

regulations established through TennCare's Medicaid Managed Care Program by The State of Tennessee, Department of Finance and Administration, Division of TennCare.

Table of Contents

1.00 General Information

1.01 Member Rights and Responsibilities

A. Introduction

The mission of DentaQuest is to expand access to high-quality, medically necessary, and compassionate health care services within the allocated resources. DentaQuest is committed to ensuring that all Dental Program Members are treated in a manner that respects their rights and acknowledges Members' responsibilities.
Members have the right to receive medical services and have certain responsibilities to aid in receiving them in accordance with TennCare^{SM} Rules 1200-13-01 et seq. The following is a statement of Member Rights and Responsibilities.

B. Member Rights

Member rights include but are not limited to the following:

- to be treated with respect and recognition of their dignity and need for privacy
- to be provided with information about the organization, its services, the practitioner providing care, and Member rights and responsibilities
- to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners
- to participate in decision-making regarding their dental care
- to voice complaints or appeals about the organization or care provided
- to be guaranteed the right to request and receive a copy of his or her dental records and to request that they be amended or corrected as specified in 45 CFR part 164
- to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- to be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the DBM and Its providers or The State agency treat the Member, and
- to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.

Additional Member rights are as follows:

Confidentiality

All dental information about TennCare Dental Members is confidential. Members have the right to be treated with respect and recognition of their dignity and need for privacy when receiving their dental care. Provider and DentaQuest will ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization. Provider and DentaQuest shall hold confidential all information obtained by its personnel about Members related to their examination,

care and treatment and shall not divulge it without the Member's authorization, unless:

- it is required by law
- it is necessary to coordinate the Member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
- it is necessary in compelling circumstances to protect the health or safety of an individual.

Release of information shall be reported to the Member prior to disclosure to give the Member sufficient time to object should the Member wish to. Member records may be disclosed, whether or not authorized by the Member, to qualified personnel for the purpose of conducting scientific research that has been approved by an Institutional Review or Privacy Board, but these personnel may not identify, directly or indirectly, any individual Member in any report of the research or otherwise disclose participant identity in any manner.

DentaQuest and the Provider shall ensure all materials and information directly or indirectly identifying any current or former Member which is provided to or obtained by or through DentaQuest's performance of its contract with TennCare,
whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated (T.C.A.), Title 42, Part 2, Code of Federal Regulations, the Privacy Act of 1974, 5 USC 552a, the Medicaid regulations, 42 Code of Federal Regulations 431.300 et seq., IRC Section 6103(p), and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to TennCare, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees.

Informed Consent

A Member's consent is required for all treatment unless there is an emergency and the Member's life is in danger. Members have the right to participate in decisions regarding their health, including consent to have invasive treatment. If written consent is required for special procedures, such as surgery, Members must understand the procedure and why it is advised. Should Members not want a particular treatment, they have the right to discuss their objections with their Provider, who will advise and discuss options. The final decision is up to the Member.

Emergency Services

A member can access a DentaQuest dentist for emergencies 24 hours a day, seven days a week. A member should ask their provider how to contact him or her in an emergency. Their provider may have a different telephone number to call in an emergency.

Dental Records

Members have the right to request access to their dental records as provided by State and federal laws. When transferring to another dental provider, Members have the right to request access to their dental records free of charge.

Members have the right to request restriction of uses and disclosures. Provider must accommodate reasonable requests by Members to receive communications of PHI from the provider by alternative means or at alternative locations.

Provider must permit Members to request that the provider amend the PHI in the Member's record. Provider may require that Members make the request in writing and provide a reason to support a requested amendment.

Members have the right to receive an accounting of disclosures in the six (6) years prior to the date the Member requests the accounting.

For the most up to date and detailed information regarding HIPAA and Member rights go to http://www.hhs.gov/ocr/privacy/index.html

Discrimination

Members should receive culturally competent care, and they have the right to receive health care, free from discrimination on the basis of their age, sex, race, color, religion, physical or mental handicap, national origin, economic status or payment source, type/degree of illness or condition, or any other classification that is protected by federal and state laws and regulations.

Providers shall agree to cooperate with DentaQuest and TennCare during discrimination complaint investigations. In addition, the Provider must assist members in obtaining discrimination complaint forms and assistance from DentaQuest with submitting the forms to TennCare. More information about civil rights compliance, including forms, policies, and notices can be found online at:

https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

and

https://www.tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html

See Appendix A of this document for a full list of forms.

DentaQuest and the Provider shall comply with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act, and Titles II and III of the Americans with Disabilities Act of 1990 in the provision of equal opportunities for members with disabilities. In the event that a mitigating measure like a reasonable accommodation/modification or effective communication assistance in alternative formats for a member is not readily achievable by the Provider, DentaQuest

shall provide the mitigating measure (i.e. reasonable accommodation/modification or effective communication assistance in alternative formats) for the member unless DentaQuest can demonstrate that the mitigating measure would impose an undue burden on DentaQuest.

Mitigating measures like auxiliary aids and services are available under Titles II and III of the ADA, Section 1557 of the Patient Protection and Affordable Care Act, and Section 504 of the Rehabilitation Act of 1973. For more guidance see:
www.ada.gov
http://www.ada.gov/taman3.html
http://www.hhs.gov/ocr/civilrights/resources/laws/index.html

Non-Discrimination Compliance Offices
Contact information for non-discrimination compliance offices are as follows:

Division of TennCare
TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243 615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

DentaQuest

- **Phone**: 262.834.3576
- **E-mail:** DentaQuest.fairtreatment@dentaquest.com

You can also write to:
Non-discrimination Compliance Coordinator DentaQuest of Tennessee, LLC
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 800.241.7366
TDD: Toll Free 1.800.417.7140 ext. 43576
Local 262.834.3576

Language Assistance Services
According to federal and state regulations of Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act, translation or interpretation services needed to effectively communicate with a Limited English Proficiency (LEP) individual is to be provided by the entity at the level at which the request for service is received. Pursuant to the Executive Order signed August 11, 2000, by former President William Clinton, the U.S. Department of Health and Human Services issued guidance on preventing discrimination against LEP individuals at:
https://www.federalregister.gov/documents/2003/08/08/03-20179/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national

The financial responsibility for the provision of the requested language assistance is

that of the entity that provides the service. Charges for these services should not be billed to **TennCare℠** and it is not permissible to charge a TPPOHP Member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found on line at http://www.justice.gov/crt/about/cor/coord/titlevi.php.

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of **TennCare℠** Members. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found on line at http://www.lep.gov/ISpeakCards2004.pdf.

And you can find more resources for effectively communicating with individuals and civil rights compliance information at TennCare's Provider Civil Rights Information webpage at:

https://www.tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html

The Department of Health and Human Services can also recommend resources for use when LEP services are needed at:

https://www.hhs.gov/civil-rights/for-providers/index.html

If you cannot locate interpreters specializing in meeting needs of LEP clients, call the translation numbers listed at the front of this guide.

Providers may also consider:

- Training bilingual staff
- Utilizing telephone and video services
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

Advance Directives

Members have the right to determine their treatment by issuing advance directives (legal provisions that allow their wishes to be carried out when they are incapable of making important health decisions). These directives may include:

- A living will to express the Member's wishes concerning life-sustaining treatment by artificial means when terminally ill
- A durable power of attorney for health care that gives an individual appointed by the Member the authority to make decisions regarding the Member's treatment; or
- Nominating a guardian or conservator, a court-appointed individual who represents the Member's interests when he/she is unable to make independent decisions.

Member Appeals

Members shall have the right to file appeals regarding adverse actions taken by DentaQuest or the Provider. The term "Appeal" shall mean a Member's right to

contest verbally or in writing, any “Adverse Action” taken by DentaQuest or the Provider to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of DentaQuest or the Provider that impair the quality, timeliness, or availability of such benefits. An Appeal may be filed by the Member or by a person authorized by the Member to do so, including but not limited to, a Provider with the Member's consent. DentaQuest shall inform Members of their Appeal rights in the Member Handbook. See section 7.00 of this manual for specific Appeal guidelines.

Member Grievance

A Member “Grievance” shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does NOT meet the definition of Adverse Benefit Determination. For example, a Complaint may arise due to how the Member was treated by the Provider or the Provider’s staff during an office visit (i.e. rude or inappropriate behavior or not answering the Member’s questions) or if the Member feels that a DentaQuest staff Member treated him/her inappropriately (i.e. being rude during a phone call, or not returning a Member’s phone calls). DentaQuest shall inform Members of their Grievance rights in the Member Handbook. DentaQuest and TennCare take Member’s Complaints very seriously and require Providers to do the same. See section 7.03 of this manual for specific guidelines pertaining to handling Member Grievances.

Information

Members have the right to be provided with information about the services offered by TennCare[SM], DentaQuest, or the dental practitioner providing the care and their own personal rights and responsibilities.

C. Member Responsibilities

Enrollment in the TennCare Dental Programs carries certain Member responsibilities. While all Members receive a handbook that details those responsibilities, Providers are also encouraged to familiarize themselves with Member responsibilities. Those responsibilities include:

- Knowing and understanding the terms, conditions, and provisions of participating in the dental programs and abiding by them.
- Following preventive health guidelines, prescribed treatment plans and guidelines given by those providing health care services.
- Scheduling or rescheduling appointments and informing the Provider when it is necessary to cancel an appointment.
- Showing member’s MCO ID card whenever receiving health care or prescription medication.
- Providing, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health services.
- Closely following the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
- Participating in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible

1.02 Provider Rights and Responsibilities

A. DentaQuest Participating Providers have a right to:

- Receive information about the TennCare Dental Programs, services, and Members' rights and responsibilities.
- Be informed of the status of their credentialing or re-credentialing application, upon request.
- Object to rules, policies, procedures, or decisions of DentaQuest, or TennCare relative to the TennCare Dental Programs, as set forth in this document and the provider agreement.
- File an appeal as delineated in this Provider Office Reference Manual.
- Not be discriminated against with regard to participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- Not be discriminated against for specializing in conditions that require costly treatment.
- As a participant in a program receiving federal funds, you should not be subjected to discrimination because of your race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.
- Recommend a course of treatment to a Member, even if the course of treatment is not a Covered Service or approved under the TennCare Dental Programs. However, the Provider must inform the Dental Member that TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare Dental Programs.
- Communicate with Members regarding dental/treatment options.
- Specify the functions and /or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional practice. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the TennCare Dental Programs.
- Discontinue treatment of a Member with whom the practitioner feels he/she cannot establish or maintain a professional relationship.

B. TennCare Dental Program Participating Providers have the responsibility to:

Screen all employees and contractors to determine whether any of them have been excluded from participation as a Medicaid provider. This obligation is a condition of a Provider's enrollment as a Medicaid provider and is also a continuing obligation during a Provider's entire term as such. Provider acknowledges that as a Medicaid provider, Provider is required and agrees to search the Health and Human Services Office of Inspector General (HHS-OIG) website monthly to learn of persons who have been excluded and reinstated as Medicaid providers. Provider is required and agrees to immediately report any exclusion information discovered relating to its employees or contractors to DentaQuest. The National Practitioner Data Bank (NPDB) is a federal data bank which was created to serve as a repository of information about health care

providers in the United States. NPDB can be used a source of data to obtain any exclusions reported regarding a given provider.

- Recognize and abide by all applicable State and Federal laws, regulations, rules, policies, court orders and guidelines and the requirements of the Provider Agreement, its attachments, and this DentaQuest Office Reference Manual (ORM). This includes monthly checks of the Providers' employees and contractors against the federal U.S. Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities (LEIE) database for excluded providers.
- The provider shall give TennCare, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, the Tennessee Bureau of Investigation Medicaid Fraud Control Division (TBI MFCD), Department of Health and Human Services Office of the Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, or their designees, access to their records. Said records shall be made available at no cost to the requesting party and furnished immediately upon request by the provider for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the Contractor, or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to, the OIG, the TBI MFCD, the DHHS OIG and the DOJ or their designees;
- Assist in such reviews including the provision of complete copies of dental records.
- Provide at no cost to a Member or Member's new dental Provider all dental/medical records when care is being transferred to another dentist.
- Allow participation by the Member in the decision-making regarding the Member's dental care.
- Discuss appropriate or medically necessary treatment options for the Member's conditions, regardless of cost or benefit coverage. However, TennCare will only pay for covered services that are medically necessary that the Member is eligible to receive under the applicable TennCare Dental Program.
- Provide information that DentaQuest and TennCare require to evaluate the quality of care and service.
- Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.
- Serve as a conduit to the practitioner community regarding the dissemination of health care information.
- Notify Member in writing if a recommended service or supply is not a Medically Necessary Covered Service and obtain a written waiver from the Member prior to rendering such service that indicates the Member was aware that such service or supply is not a Medically Necessary Covered Service and that the Member agrees to pay for such service or supply if provided. This waiver should also be obtained if the service is to be covered as an IME.
- Abide by the accessibility and availability standards as set forth in Section 3 of the Provider Agreement.

- Ensure that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.
- Offer hours of operation that are not less than the hours of operation offered to commercial members and ensure that the office waiting time shall not exceed forty-five (45) minutes.
- Make Member appeal forms available at the service site. Display notices of Member's right to appeal Adverse Benefit Determinations affecting services in public areas of their facility(s). DentaQuest shall ensure that the providers have the correct and adequate supply of public notices. The Notice must be displayed in a conspicuous location (i.e. waiting room, check-in window, check-out window).
- Supply accurate, relevant, factual information to a Member in connection with an appeal filed by the Member.
- Ensure that TennCare is the payer of last resort. Thus, Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim to DentaQuest for payment by TennCare.
- Document services declined by a parent, guardian or mature competent member and specify the service declined.

C. Annual Informational Sessions and Webinars

DentaQuest and the Division of TennCare strongly encourage all providers to attend as many offered sessions as possible and a minimum of one annually. Invitations to sessions and webinars will be posted on the portal and sent via email so you can attend.

1.03 Provider Data and Operations

A. Updating Your Information

It is important to ensure that you provide updates to DentaQuest at least 30 days in advance for any changes in information for your practice per your provider agreement. The Division of TennCare has requested we send out all communications by email so having a valid up to date email on file with DentaQuest is critical to ensure you receive all communications in a timely manner. What you provide to DentaQuest should match what you attest to quarterly in CAQH. An update form can be found in the forms section of this manual and should be emailed to standardupdates@dentaquest.com

Types of updates:

- Business (Tax ID)
- Credentialing Correspondence
- EFT/Payment
- License Change
- Name Change
- Location (Provider) Add/Term/Update

B. Existing Patients Only Policy

DentaQuest is updating the policy in regard to existing patients only. As of May 1, 2019 the following criteria is implemented for existing patient only (EPO) requests:

- 30 day advance written notice and a completed update form is required to be submitted
- Requests will be honored for a 90 day span from date of submission
- At the end of the 90 day timeframe your EPO status will be removed

C. TennCare Policy Links

- Timely Filing
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pay06002.pdf
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf

- Coverage Adult Dental in ER
  https://www.tn.gov/content/dam/tn/tenncare/documents2/ben06002.pdf

- Cost Effective Alternatives
  https://www.tn.gov/content/dam/tn/tenncare/documents2/ben08001.pdf

- False Claims Act Policy
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pi08001.pdf

- Orthodontia Providers
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pro05001.pdf

- Provider Terminations for Inactivity
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pi13001.pdf

The policies below are for provider billing:

- Third Party Co-Pays and Deductibles

  https://www.tn.gov/content/dam/tn/tenncare/documents2/con05001.pdf

- Third Party Liability
  https://www.tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf

- When A Provider May Bill A TennCare Member
  https://www.tn.gov/content/dam/tn/tenncare/documents2/pro08001.pdf

2.00 Member Eligibility Verification

2.01 State Eligibility System

The State of Tennessee provides the most up-to-date on-line eligibility access through Tennessee Anytime. For instructions, please go to https://www.tn.gov/tenncare/providers/verify-eligibility.html

2.02 DentaQuest Eligibility System

DentaQuest does not issue eligible Members ID cards. Cards are often out of date or lost by Members. It is the Provider's responsibility to check the databases available to confirm eligibility before providing services. TennCare will only pay for covered services that are medically necessary and that the Member is eligible to receive under the applicable TennCare Dental Program. If the Provider fails to verify that the Member is eligible for the services rendered and it is later determined that the Member was not eligible, TennCare will not pay the Provider for the services rendered, and the Provider may not collect or attempt to collect the cost of such services from the Member, except as provided in Section 2.04 below.

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed via 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 at 855-418-1623; 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 website currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or the Member's full last name and first initial. To access the eligibility information via DentaQuest's website, simply go to 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. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 855-418-1623. Once logged in, select "Patient" and then "Member Eligibility Search" and from there 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 855-418- 1623. 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 855-418-1623.

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.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 855-418-1623. They will be able to assist you in utilizing either system.

2.03 Member Liability

Providers may seek payment from TennCare Dental Members, including billing a service as IME, only in the following situations:

- If the services are not covered by the TennCare Dental Program and, prior to providing the services, the Provider informed the Member the services are not covered. The Provider is required to inform the Member of the non-covered service and have the Member acknowledge the information. If the

Member still requests the service, the Provider shall obtain such acknowledgment in writing prior to rendering the service.

- If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the Member that the services are not covered, the Member may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

Providers may not seek payment from DentaQuest Members when:

- The Provider knew or should have known about the Member's TennCare Dental Program eligibility or pending eligibility prior to providing services.
- The claim(s) submitted to DentaQuest for payment was denied due to Provider billing error or a DentaQuest claims processing error.
- The Provider accepted DentaQuest assignment on a claim and it is determined that a primary plan paid an amount equal to or greater than the applicable TennCare Dental Program allowable amount.
- The Provider failed to comply with applicable TennCare Dental Program policies and procedures or provided a service that lacks Medical Necessity or justification.
- The Provider failed to submit or resubmit claims for payment within the time periods required by DentaQuest.
- The Provider failed to ascertain the existence of TennCare Dental Program eligibility or pending eligibility prior to providing non-emergency services. Even if the Member presents another form of insurance, the Provider must determine whether the Member is covered under TennCare.
- The Provider failed to inform the Member prior to providing a service not covered by the applicable TennCare Dental Program that the service was not covered, and the Member may be responsible for the cost of the service. Services which are non- covered by virtue of exceeding limitations must always be discussed prior to providing service and billing Member.
- The Member failed to keep a scheduled appointment(s). If the provider has a fee for un-canceled, unattended visits, that must be covered upon enrollment with the provider, clearly stated, and signed off on by the member.
- The Provider failed to follow Utilization Management (UM) notification, Tennessee Dental Director, or prior authorization policies and procedures.

2.04 Coordination of Benefits

TennCare is the payer of last resort. Dental claims submitted to DentaQuest for

payment by TennCare must be submitted to the primary dental insurance (when applicable) prior to submission to DentaQuest for payment.

Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim to DentaQuest for payment by TennCare and ensuring that TennCare is the payer of last resort. Always submit the primary payment on the claim submitted. Please confirm that this has been completed prior to submitting claims to DentaQuest to avoid delayed reimbursement

In accordance with TennCare Dental Program policy CON05-001, TennCare's payment for a covered service, less any applicable Medicaid deductibles or copays is considered payment in full. Participating providers are required to accept TennCare's payment as payment in full.

3.00 Utilization Management

3.01 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. For the TennCare Dental Programs, which are a part of Medicaid, the State Legislature annually budgets the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is no patient co-payment, these dollars represent all the reimbursement available to the dentist, and since they are limited in nature, make fair and appropriate distribution to the dentists of crucial importance.
DentaQuest will review prior authorization requests submitted to determine the medical necessity for dental treatment and the dentist must not divert from that treatment unless additional approval is given by DentaQuest or except in a case of emergency. Diverting from a previously authorized service poses concerns with the authorization process, billing and payment.

3.02 Community Practice Patterns

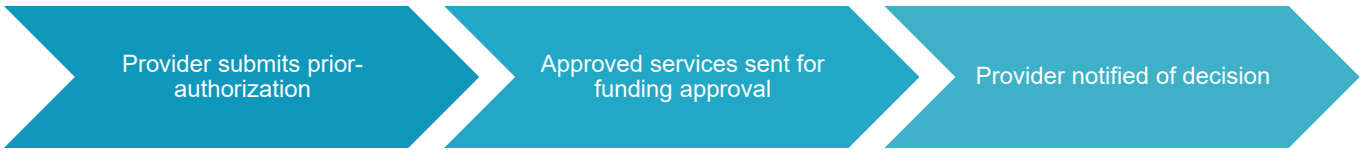
DentaQuest believes that there is a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. DentaQuest's Utilization Management Programs are designed to ensure the fair and appropriate distribution of TennCare Dental Program 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 community practice patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal 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.

Where community practice patterns are inconsistent with TennCare's medical necessity criteria and the medical necessity guidelines presented in this Office Reference Manual, medical necessity rules and guidelines will take precedence.

3.03 ECF CHOICES/ 1915(c) Waiver Program Workflow

Quick Look



- Authorization submitted via provider portal
- DentaQuest will be notified of available funds
- Provider may render services and submit claim for payment

Detailed Workflow

Prior-Authorization

- All services not covered through TennCare Adult benefits must be prior-authorized through the ECF CHOICES/1915(c) Waiver Programs
- Providers should submit prior-authorization requests via their provider portal
- Only one prior authorization will be needed for these members. Prior authorizations will be reviewed for Adult coverage first and any non-covered services will automatially be reviewed for IDD coverage.
- Prior-authorizations should be submitted on an ADA claim form along with all documentation available to support medical necessity of the requested services
- A DentaQuest dental director that is solely dedicated to ECF CHOICES/1915(c) Waiver Programs will review each prior-authorization request for medically necessity

Funding Approval

- All services approved for medical necessity will be sent to ensure funding is available
- The member or their support person will also review the approved services to ensure they want to use ECF CHOICES/1915(c) Waiver Program funds for the services
- DentaQuest will be notified if funding is authorized for approved services
- **Covered Services for eligible adults age 21 and older in the TennCare ECF CHOICES and 1915(c) Waiver DBM Programs shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years. Services covered by TennCare Adult Dental will not apply to this maximum.**

Provider Notified of Decision

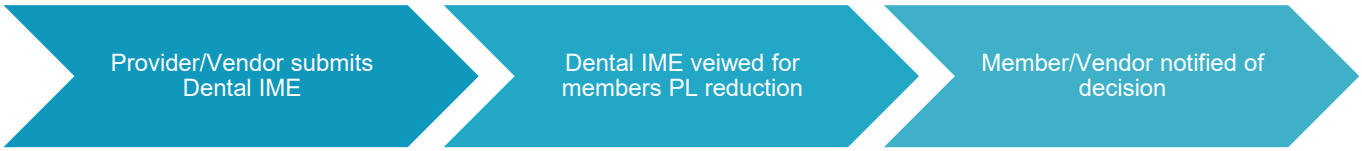
- Outcome of the prior-authorization review will be sent to provider
- Decision will indicate if the services were:
  - approved for both medical necessity and funding (providers may move forward with rendering and billing DentaQuest for these services)
  - approved for medical necessity but denied due to unavailable funding (providers may complete these services at the expense of the member if all are in agreement, these services will not be paid by DentaQuest)
  - denied for medical necessity (providers are not permitted to complete these services)

Payment

- Once services approved for medical necessity and funding are rendered, providers may submit a claim to DentaQuest for payment.
- See section 5.00 (5.01 & 5.06) of the ECF CHOICES/1915(c) Waiver Programs Office Reference Manual for instructions on how to submit claims.

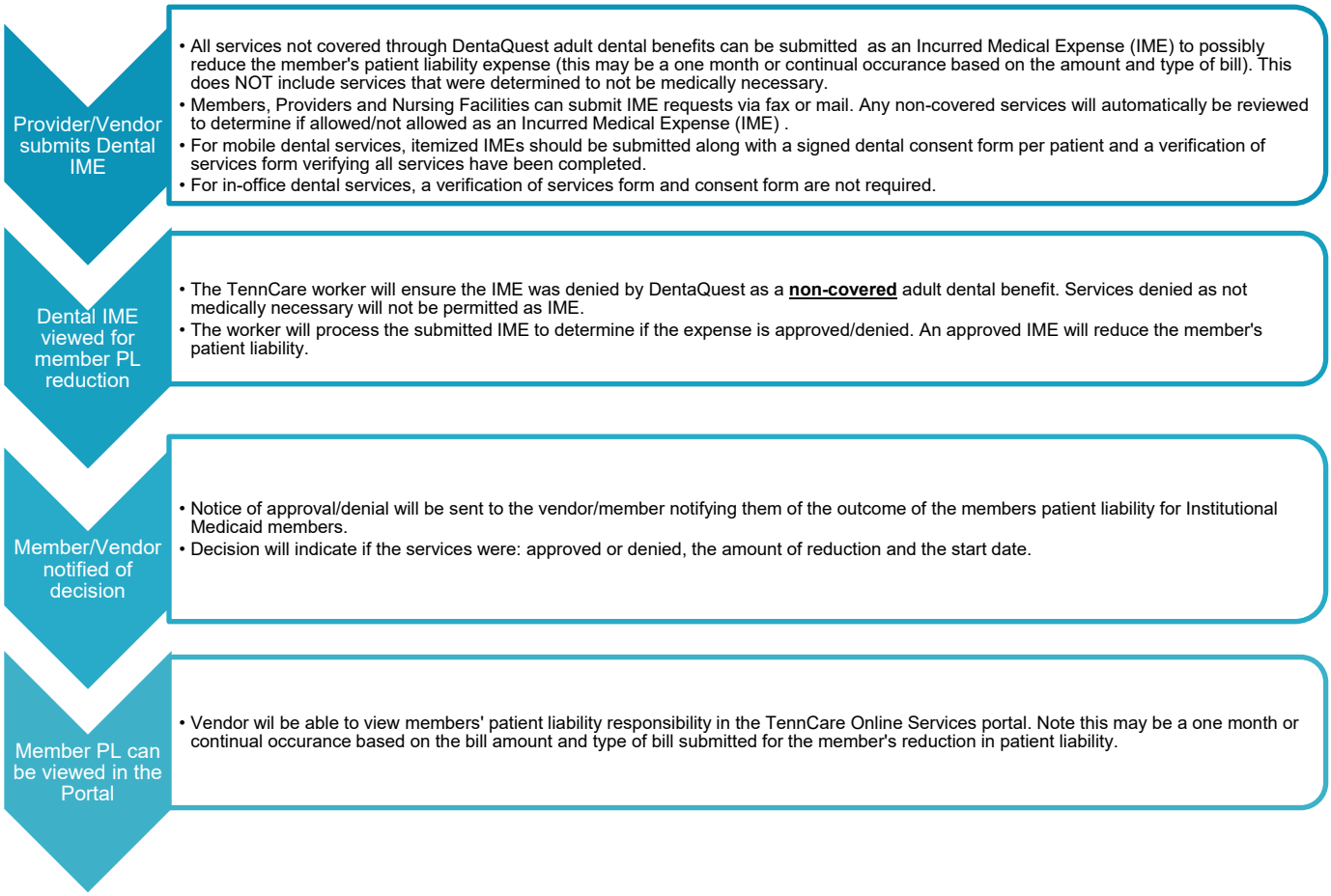
3.04 Nursing Facility and ICF/IID with Incurred Medical Expenses (IME) Workflow

Quick Look



- IME submitted to TennCare
- IME processed for Approval/Denial
- Member/Vendor sent notice of decision

Detailed Workflow



INCURRED MEDICAL EXPENSE (IME) – Expenses used to reduce patient liability for Institutional Medicaid members. These are commonly referred to as Item Ds; Expenses, not subject to third party payment, incurred the three months prior to

application, unpaid or paid during the month(s) of eligibility determination, or during periods of eligibility may be deducted from the patient liability.

PATIENT LIABILITY -is the amount of income an individual must contribute to his cost of care for LTSS services, e.g., HCBS or NF services. Patient liability is determined based on available income, and certain allowable deductions from available income.

- Mobile Dental
    - Must have signed consent form
        - The date the consent form was signed must be before the procedure was performed.
    - Must have verification of services form
        - This date must match the DOS on the invoice/bill
    - Must have an Itemized list of charges
- An IME submission for tele- dentistry must include:
    - A verification of service/item received.
        - This date must match the DOS on the invoice/bill
    - Consent for receipt of service/item.
    - Information relating to medical necessity.
    - Other identifiers relating to the IME, including provider number and a description of the service/item received.
    - The verification of services form will need to be completed and signed by a representative from the long-term care facility to verify that the services were provided. An original handwritten signature is not required; an electronic or handwritten signature transmitted by fax or other electronic submission is also acceptable.
    - If the member has dental insurance or if it's a duplicate bill that has been previously paid, we will deny the submitted IME.

3.05 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.

3.06 Results

With the objective of ensuring the fair and appropriate distribution of the budgeted TennCare 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 be given education on how to modify their diagnosis and treatment processes that bring their practices back within the normal range for TennCare Dental Program Members. However, in some isolated instances, it may be necessary to recover reimbursement for payments made for services that were not medically necessary.

3.07 Medical Necessity Guidelines

Medically Necessary is defined by statute in TCA § 71-5-144. These laws are implemented in TennCare rules 1200-13-13-.01 and 1200-13-16 as well as the clinical criteria in this manual. The following are the basic medical necessity criteria.

To be medically necessary, a medical item or service must satisfy each of the following criteria:

- It must be recommended by a licensed physician who is treating the Member or other licensed healthcare provider practicing within the scope of his or her license who is treating the Member
- It must be required in order to diagnose or treat a Member's medical condition
- It must be safe and effective
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the Member's medical condition.

The convenience of a Member, the Member's family, the Member's caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.

4.00 Inpatient/Outpatient Hospital and Mobile Anesthesia Services

NOTE: Inpatient/Outpatient hospital and Mobile Anesthesia services are a covered benefit for the ECF CHOICES/ 1915(c) Waiver Program but they **are not** a covered benefit for the Adult Dental Program.

4.01 Prior Authorization

Any proposal to render covered services that are medically necessary in an inpatient or outpatient surgical setting or using a mobile anesthesia provider for ECF CHOICES/1915(c) Waiver programs must be submitted to DentaQuest for prior authorization. The request must include:

- Completed TennCare Dental Program Inpatient and Outpatient Hospital Readiness Pre-Admission Form - see Appendix A of this manual,
- Copy of the patient's dental record including health history, charting of the teeth and existing oral conditions,
- Appropriately labeled diagnostic radiographs or caries-detecting intraoral photographs*,
- Copy of treatment plan. Note: A completed ADA claim form submitted for an authorization is considered to be the treatment plan,
- Narrative describing medical necessity for hospital services.
- Completed Comprehensive Medical Consultation Form from the pregnancy/postpartum healthcare provider authorizing sedation of the pregnant patient.

* On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intraoral photographs to be made in the dental office setting. If this occurs, it must be noted in the patient record and on the Inpatient and Outpatient Hospital Readiness Pre-Admission Form (see Appendix A of this manual for required form). However, once the patient is sedated in a medical facility, appropriate diagnostic radiographs and/or intraoral photographs must be made to satisfy the authorization/ medical necessity requirements. Dentists who "routinely" fail to submit radiographs or intraoral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, prosthodontics, or multiple crowns may require a second opinion.

DentaQuest will review prior authorization treatment plans submitted to determine the medical necessity for dental treatment in a medical facility. The preauthorization of dental treatment will be processed by DentaQuest. DentaQuest will coordinate with the MCO as necessary. Please note that DentaQuest is not responsible for paying facility

or related anesthesia charges associated with the provision of covered services that are medically necessary performed in an inpatient, outpatient, or free-standing ambulatory surgical center. DentaQuest shall provide a prior authorization number to such Providers for inclusion on a UB-92 or HCFA 1500, as applicable that shall be submitted directly to the Member's MCO.

Non-emergency hospitalization is appropriate in the following situations:

- Documentation of psychosomatic disorders that require special handling. Hospitalization is not solely based upon reducing, avoiding or controlling apprehension. Cognitively disabled individuals where prior history indicates hospitalization is appropriate.
- Hospitalized individuals who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.
- Other medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures,
- A medical history of uncontrolled bleeding, severe cerebral palsy, or other medical conditions that render in-office treatment not medically acceptable.
- A medical history of uncontrolled diabetes, in a situation where oral and maxillofacial surgical procedures are being performed.

Please note that a physician's written authorization is required if hospitalization is requested for an institutionalized individual.

4.02 Participating Hospitals and Surgery Centers for ECF CHOICES/1915(c) Waiver Programs

Upon approval, participating dentists are required to administer services at the Member's MCO's participating hospitals when services are not able to be rendered in the dental office. Participating dentists routinely bringing cases to medical facilities should obtain privileges at multiple facilities.

Participating Hospitals may change. Please contact plan for current listing.

Amerigroup

BlueCare

United Healthcare Community Plan

4.03 Mobile Anesthesia Guidelines for ECF CHOICES/1915(c) Waiver Programs

If a DentaQuest contracted provider for TennCare or CoverKids' dental programs in Tennessee wants to utilize the services of a dental or medical anesthesia provider, group, or mobile service at their office location, they must do the following:

1. DentaQuest dental providers must submit a prior authorization request for all treatment they are planning to render. They must also include the request for mobile anesthesia in box 35, just as they do now for a request for treatment in a hospital or ambulatory surgery center.

2. DentaQuest dental providers must complete an Outpatient Hospital Readiness form and submit with the prior authorization, just as they do now for a request for treatment in a hospital or ambulatory surgery center.

3. Once Short Procedure Units (SPU) are approved on DentaQuest's prior authorization, DentaQuest dental providers must work with the anesthesia provider to submit and receive approval for the sedation services from the member's Medical MCO.

4. The dental or medical anesthesia provider, group, or mobile service must be:

    a. Credentialed with TennCare and have an individual and (if applicable) group MAID

    b. Credentialed with the member receiving treatment's Medical MCO

    https://www.tn.gov/tenncare/providers/provider-registration.html

    Provider.Registration@tn.gov

5. All DentaQuest dental providers must meet all requirements stated in their provider agreement and respective Office Reference Manual.

In addition, providers who choose to work with a dental or medical anesthesia provider, group, or mobile service at their office location must maintain full compliance in accordance with the following

6. Must meet all applicable TN board of dentistry and board of medicine rules:

    a. 0460-02.20190812.pdf (tnsosfiles.com)

    b. Code 63-7-126- TN Law for Advanced Practice Nurses

    c. TN Board of Dentistry Rules – Direct Supervision (Sedation) dental.health@tn.gov

d. Rule 0460-02-.07(6)(a) A dentist who utilizes a Certified Registered Nurse Anesthetist (CRNA) to administer conscious sedation must have a valid comprehensive conscious sedation permit.

e. Rule 0460-02-.07(7)(a) A dentist who utilizes a Certified Registered Nurse Anesthetist (CRNA) to administer deep sedation/general anesthesia must have a valid deep sedation/general anesthesia permit.

7. Must meet all applicable TN regulations or statutes:

   a. Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-5-105, 63-5-107, 63-5-108, 63-5-112, 63-5-115, 63-5-117, 63-5-122, and 63-5-124.

8. Must meet all applicable TennCare billing guidelines:

   Timely Filing
   https://www.tn.gov/content/dam/tn/tenncare/documents2/pay06002.pdf

   https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf

   Coverage Adult Dental in ER
   https://www.tn.gov/content/dam/tn/tenncare/documents2/ben06002.pdf

   Cost Effective Alternatives
   https://www.tn.gov/content/dam/tn/tenncare/documents2/ben08001.pdf

   False Claims Act Policy
   https://www.tn.gov/content/dam/tn/tenncare/documents2/pi08001.pdf

   Orthodontia Providers
   https://www.tn.gov/content/dam/tn/tenncare/documents2/pro05001.pdf

   Provider Terminations for Inactivity
   https://www.tn.gov/content/dam/tn/tenncare/documents2/pi13001.pdf

   Third Party Co-Pays and Deductibles
   https://www.tn.gov/content/dam/tn/tenncare/documents2/con05001.pdf

   Third Party Liability
   https://www.tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf

   When A Provider May Bill A TennCare Enrollee
   https://www.tn.gov/content/dam/tn/tenncare/documents2/pro08001.pdf

9. Must meet all applicable CMS rules

   a. 140.4.4 Qualified Non-physician Anesthetist and an

5.00 Claim Submission

DentaQuest strongly encourages all contracted Providers to submit claims electronically.
DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D IB_5010 File.
- Paper ADA approved dental format

5.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 855-390-6424.

Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry." The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

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

EDITeam@greatdentalplans.com

5.02 Electronic Attachments

FastAttach™

DentaQuest accepts dental radiographs electronically via FastAttach™ for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and remittance advice.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea- fast.com or call NEA at: 800.782.5150

5.03 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724- 7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and

Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

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

Please note *Place of Service* is a required field on the ADA claim form. Claims not specifying *Place of Service* will be denied.

5.04 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.

5.05 NPI Requirements for Submission of Electronic Claims

In accordance with the Federal law, 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 NPPESS website and provide this information to DentaQuest Dental in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest 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.

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

Claims should be mailed to the following address:

DentaQuest Claims (*Program name here***)**
PO Box 2906
Milwaukee, WI 53201-2906

5.07 Coordination of Benefits

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.

5.08 Filing Limits

Participating Provider shall have no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file an initial claim with

DentaQuest except in situations regarding coordination of benefits or subrogation in which case the Provider is pursuing payment from a third party or if a Member is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that DentaQuest receives notification from TennCare as to the Member's eligibility in a TennCare Dental Program.

In the event that a provider has a filed a claim within the required 120 day filing period, but the claim is denied as a result of administrative guidelines such as: missing documentation, Member eligibility status, missing claim details, the claim may still be considered for reimbursement. Upon receipt of the missing information or change in Member status, DentaQuest will reconsider the claim denial if the initial filing timeline can be verified as occurring within the required 120 filing period and the additional information received is sufficient to meet payment guidelines. In this scenario, DentaQuest will honor the initial filing date and process the claim accordingly.

**Please note: DentaQuest's system will not automatically override the filing limits, therefore, a provider must contact DentaQuest provider services to assist with the handling of the claim to ensure that it does not deny for untimely filing.

5.09 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 at 855.418.1623 with any questions you may have regarding claim submission or your remittance.

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

5.10 Electronic Funds Transfer EFT (Direct Deposit)

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

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

- Complete and sign the Direct Deposit Authorization Form found on the website.
- Attach a voided check to the form. The authorization cannot be processed without a voided check.

- Return the Direct Deposit Authorization Form and voided check to DentaQuest:

  Via Fax:
  262.241.4077
  Or
  Via Mail:
  DentaQuest – TennCare PO Box 2906
  Milwaukee, WI 53201-2906
  ATTN: PDA Department

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

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as changes in routing or account numbers or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 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 Dentist Portal. Providers may access their remittance statements by following these steps:

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

5.11 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, and/or the Division of TennCare[SM] harmless for the payment of non-covered Services except as provided in this paragraph.

Providers 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 and/or the Division of TennCare[SM] will not pay for or be liable for said services; and
- Member will be financially liable for such services.

If you reach an agreement to bill a Member for a non-covered service, do not submit the claim to DentaQuest. Submission of such services will render the arrangement with the Member null and void.

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 agreements 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.

Use of Your Information

As a Participating Provider or a Participating Practice, you authorize DentaQuest, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) 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 name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this dental ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its

affiliates may also disclose Participating Practice's and Participating Provider's 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 such personal information to third parties, we require them to protect the privacy and security of this information.

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 2023-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT 2023 -4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 855.390.6424 or via e-mail at denelig.benefits@dentaquest.com.

7.00 Appeals and Grievances

DentaQuest adheres to State, Federal, program requirements related to processing inquiries and appeals.
Note:
Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 855.418.162.01 Member Appeal Process

If a provider receives a notice from DentaQuest advising that provider's prior authorization request has been denied, the TennCare Dental Member will have also received the Notice of Adverse Benefit Determination (NABD) that details the member's appeal rights.

In the event that a dental service prior authorization request is denied by DentaQuest, the TennCare Dental Member has the right to appeal the denial to TennCare. With the member/member parent or guardian's oral consent, a provider may file a TennCare service appeal on the member's behalf. The NABD instructs how to file such an appeal with TennCare either over the telephone or in writing.

Once a member appeal is filed, TennCare will conduct an appeal as required under Federal law. If the Appeal finding upholds the adverse benefit determination, the Member will have the option to request a State Fair Hearing as provided for under Federal law to review the Appeal finding. If the Hearing process results in a decision overturning DentaQuest's denial, DentaQuest will be instructed by TennCare to approve provision of the service.

PLEASE NOTE:
The TennCare member appeals process does not handle provider issues which have not resulted in an Adverse Benefit Determination affecting the TennCare Dental Member's receipt of a benefit. For example, payment disputes between the provider and DentaQuest must NOT be filed as TennCare member appeals. If resolution of the issue under dispute does not affect whether the TennCare Dental Member will receive a service (or reimbursement of a service), then the appeal should be filed as a Provider Appeal.
See section 7.02 for an explanation of the Provider Appeal process.

Rights and Responsibilities Regarding Member Appeals

TennCare Dental Members have the right to appeal any Adverse Benefit Determination taken by DentaQuest. An Adverse Benefit Determination is anything that denies, reduces, terminates, delays, or suspends a TennCare dental covered service, as well as any acts or omission which impair the quality, timeliness, or availability of TennCare dental covered services.

Appeals involving denials of authorizations for care for TennCare Dental Members may be lodged by the member or by anyone (including the treating provider) acting on the

member's behalf. Dental providers play an important role in the appeal process for TennCare Dental Members. Among providers' responsibilities is the obligation to supply at no cost to TennCare or DentaQuest, those medical and dental records necessary to substantiate the member's appeal.

7.02 Provider Appeal Process (Post-Service Appeals)

Providers have multiple options to appeal a decision post-service.

DentaQuest Provider Appeals

Participating Providers that disagree with claims processing determinations made by DentaQuest may submit a written notice of disagreement to DentaQuest that specifies the nature of the issue. The Provider Appeal form, located in Appendix A-9, can be used for this purpose. The appeal must be sent within 60 days from the date of the original determination.

All provider appeals received timely by DentaQuest will be reviewed by the Complaints and Grievances department for review and reconsideration, which includes review by a clinical professional. The department will respond in writing with its decision to the Provider.

Tennessee Department of Commerce and Insurance Complaint Process

The TDCI Provider Complaint process is a courtesy provided to dental providers who have a complaint against DentaQuest. This process is free.

Complaints may involve claims payment accuracy and timeliness, credentialing procedures, inability to contact or obtain assistance from DentaQuest, miscommunication or confusion around DentaQuest policy and procedures, etc.

When a provider complaint is received, the TDCI TennCare Oversight Division will forward the complaint to DentaQuest for investigation. DentaQuest is required to respond in writing to both the provider and the TennCare Oversight Division by a set deadline to avoid assessment of liquidated damages or other appropriate sanction. If the provider is not satisfied with DentaQuest's response to the complaint, the provider may seek other remedies to resolve the complaint, including but not limited to, requesting a claims payment dispute be sent to an Independent Reviewer for resolution or pursuing other available legal or contractual remedies. Instructions and current copies of the forms can be obtained on the state's Web site at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution.html

TDCI TennCare Provider Independent Review of Disputed Claims

In addition to the above process, Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Dental Provider Independent Review of Disputed Claims process.

The Independent Review process was established by statute (Tennessee Code

Annotated § 56-32-126(b)(2)) to resolve claims disputes when a provider believes a TennCare Managed Care Company (MCC)such as DentaQuest has partially or totally denied claims incorrectly. A failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within sixty (60) days of DentaQuest's receipt of the claim is considered a claims denial.

There is a $750.00 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCC is responsible for paying the fee.
Conversely, if the independent reviewer finds in favor of the MCC, the provider is responsible for reimbursing the MCC the amount of the fee.

The independent review process is only one option a provider has in order to resolve claim payment disputes with a TennCare MCC. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.

7.03 Member Grievances

DentaQuest's process for handling Member Grievances against Providers and/or DentaQuest is as follows:

1. The Member Grievance process shall only be for Grievances as defined in Section 16.00. DentaQuest and the Providers shall ensure that all Member Appeals, as defined in sections 7.00 through 7.02, are addressed through the Appeals process, rather than through the Grievance process.

2. DentaQuest and the Provider shall allow a Member to file a Grievance either orally or in writing at any time.

3. Provider shall forward a copy of any written Member Grievance the Provider receives to DentaQuest within one (1) business day of receipt from Member. Provider shall forward to DentaQuest a full and complete written version of any Grievance received orally from a Member within one (1) business day of receipt from Member. All such transmissions of Member Grievance to DentaQuest shall be made electronically, via secure email or facsimile transmission.

4. Within five (5) business days of receipt of the Grievance, DentaQuest shall provide written notice to the Member and the Provider (if the Grievance was against the Provider) that the Grievance has been received and the expected date of resolution. However, if DentaQuest resolves the Grievance and verbally informs the Member, and Provider if appropriate, of the resolution within five (5) business days of receipt of the Grievance, DentaQuest shall not be required to provide written acknowledgement of the Complaint to the Member, and Provider if appropriate.

5. DentaQuest shall resolve and notify the Member and the Provider (if the Grievance was against the Provider) in writing of the resolution of each Grievance as

expeditiously as possible but no later than thirty (30) days from the date the Complaint is received by DentaQuest. The notice shall include the resolution and the basis for the resolution. However, if DentaQuest resolved the Grievance and verbally informed the Member and Provider, if appropriate, of the resolution within five (5) business days of receipt of the Grievance, DentaQuest shall not be required to provide written notice of resolution to either the Member or the Provider (if the Grievance was against the Provider).

6. DentaQuest and Providers shall assist Members with the Grievance process.

7. DentaQuest shall resolve each Member Grievance with assistance from the affected Provider, as needed, and Provider shall comply with DentaQuest's request for assistance. The resolution process includes various methods of determining the cause of, and the appropriate resolution of, a Grievance, including, but not limited to, use of a corrective action plan (CAP). A CAP is a plan to correct Provider's noncompliance with the Provider Agreement (including noncompliance resulting in Member Grievance) that the Provider prepares on his/her own initiative, or at DentaQuest's request, to submit to DentaQuest for review and approval. Provider shall respond timely to the CAP request and take all CAP actions that have been approved by DentaQuest. Failure to comply with a request to provide a CAP or the terms and conditions of an approved CAP may result in actions against the Provider, including termination of the affected Provider's Provider Agreement by DentaQuest. The various components of a CAP are as follows:

a. *Notice of Deficiency*: If DentaQuest determines that the Provider is not in compliance with a requirement of the Provider Agreement (including, but not limited to, issues relating to a Member's Grievance) DentaQuest will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Provider intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to DentaQuest and may also contain recommendations or requirements the Provider must include or address in the CAP.

b. *Proposed CAP*: Upon receipt of a Notice of Deficiency, the Provider shall prepare a proposed CAP and submit it to DentaQuest for approval within the time frame specified by DentaQuest. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.

c. *Approved CAP Implementation*: DentaQuest will review the proposed CAP and work with the Provider to revise it as needed. Once approved, the Provider shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the CAP, to DentaQuest's satisfaction.

d. *Notice of Completed CAP*: Upon satisfactory completion of the implemented CAP, DentaQuest shall provide written notice to the Provider. Until written

approval is received by the Provider, the approved CAP will be deemed to not have been satisfactorily completed.

8. DentaQuest shall track and trend all Member Grievances, timeframes and resolutions and ensure remediation of individual and/or systemic issues.

9. Upon request, DentaQuest shall submit reports regarding Member Grievances to TennCare.

10. Member Grievances pertaining to discrimination shall be handled in accordance with the separate Nondiscrimination process outlined in this manual in Section 1.01.

8.00 Fraud, Waste, and Abuse

DentaQuest is committed to detecting, reporting, and preventing potential fraud, waste, and abuse (FWA). and cooperates with oversight agencies, including but not limited to, TennCare's Office of Program Integrity (OPI), the Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD), Tennessee Attorney General and the State of Tennessee's Office of the Inspector General (OIG).

DentaQuest promptly refers any information or allegation concerning possible unethical or improper business practices by providers to Tenncare OPI and TBI MFCD.

A copy of DentaQuest's QI Program is available upon request by contacting DentaQuest's Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com

8.01 FWA Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care It also includes Member practices that result in unnecessary cost to the Medicaid program.

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.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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

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 or TennCare.

You can find more information about fraud, waste, and abuse at https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html.

8.02 Reporting Fraud, Waste, or Abuse

If you suspect fraud or abuse is being committed by **someone who receives TennCare benefits**, you may report your concerns to the Office of Inspector General in one of the following ways:

- Call the Toll-Free Hotline 1-800-433-3982 or 615-687-7200
- Email TennCare.Fraud@tn.gov

Anyone desiring to file a fraud complaint may remain anonymous, except in cases where the person reporting wants to qualify for the Cash for Tips reward. **Only** information submitted by telephone is eligible for a reward

To report TennCare **provider** fraud, waste, or abuse, you may use any of the following methods:

- Call the **TennCare Provider Toll Free Fraud Hotline** at **1-833-687-9611**
- Email TennCare Program Integrity at ProgramIntegrity.TennCare@tn.gov
- Complete the "Report Provider Fraud" form located at https://stateoftennessee.formstack.com/forms/tenncare_provider_fraud_report
- Mail your written complaint to:

  Division of TennCare
  Attn: Program Integrity Tip Department
  310 Great Circle Road
  Nashville, TN 37243
- Call the **TBI Medicaid Fraud Control Division** Toll Free Tip Hotline at **1-800-433-5454**.
- E-Mail the TBI Medicaid Fraud Control Division at TBI.MedicaidFraudTips@tn.gov
- Mail your written complaint to:

  TBI Medicaid Fraud Control Division
  901 RS Gass Blvd.
  Nashville, TN 37216

8.03 Policy and Procedure

False Claims Act Information

Purpose
To provide information about the False Claims Act (the "FCA") and related legal requirements as required by the Deficit Reduction Act of 2005.

Policy
It is the policy of DentaQuest to provide service in a manner that complies with applicable federal and state laws and that meets the high standards of professional ethics. To further this policy DentaQuest provides the following information about the role of certain federal and state laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

1. **Federal False Claims Laws**

   The FCA, 31 U.S.C. §§ 3729-2733, imposes liability on any person or entity who knowingly files an unjustified or false claim for payment to Medicare, Medicaid, or other federally funded health program.

"Knowingly" means that a person has actual knowledge that the information on the claim is false; acted in deliberate ignorance of whether the claim is true or false; or acted in reckless disregard of whether the claim is true or false. Unethical providers may tell TennCare that they provided a more expensive service than they actually did, which results in the provider receiving more money from TennCare than they should. This is known as "**upcoding**" and is a violation of the federal False Claims Act ("FCA").

A person or entity found liable under the FCA is, generally, subject to three times the dollar amount that the government is defrauded and monetary penalties for each false claim. If there is a recovery in the case brought under the FCA, the person bringing the suit may receive a percentage of the recovery. For the party found responsible for the false claim, the government may seek to exclude it from future participation in Federal healthcare programs or impose additional obligations against it.

2. **Anti-Retaliation Protection**
   DentaQuest encourages personnel to report any concerns relating to potential fraud and abuse, including false claims.

   The FCA states that no person will be subject to retaliatory action as a result of their reporting of credible misconduct.

3. **Anti-Fraud Hotline**
   The TennCare and OIG Fraud hotline can be accessed by calling 800.433.3982. We investigate all incoming calls to determine if the allegations are warranted. Based upon the information received from callers, the proper course of action is determined.

4. **Monthly Screening requirement**
   The contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. The Contractor, its subcontractors and all tax-reporting provider entities that bill and/or receive TennCare funds as the result of this contract shall screen their owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/ Entities (LEIE).

   In addition, the Contractor and its subcontractors shall screen their owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the Contractor dependent on the entity that identifies the payment of unallowable funds to excluded individuals.

   For the purpose of the Monthly Screening Requirements, the following definitions shall apply:

"Exclusion Lists" means the U.S. Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities (located at http://www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (located at https://exclusions.oig.hhs.gov/).

"Ineligible Persons" means any individual or entity who: (a) is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their monthly obligation to screen all employees and contractors (the "Monthly Screening Process") against the Exclusion Lists to determine whether any of them have been determined to be ineligible Persons, and therefore, excluded from participation as a Medicaid Provider. Providers are also required to have employees and contractors disclose whether they are Ineligible Persons prior to providing any services on behalf of the Provider. The Monthly Screening Process is a Centers for Medicare & Medicaid Services (CMS) requirement and a condition of their enrollment as a DentaQuest Medicaid Provider and is also a continuing obligation during their term as such.

Medicaid Providers must immediately report any exclusion information discovered to DentaQuest.

If Provider determines that an employee or contractor is or has become an Ineligible Person, Provider will take the appropriate action to remove such employee or contractor from responsibility for, or involvement with Provider's operations related to Federal health care programs. In such event, the Provider shall take all appropriate actions to ensure that the responsibilities of such employee or contractor have not and will not adversely affect the quality of care rendered to any DentaQuest Member of any Federal health care program.

5. **Credible Allegation of Fraud**
   Pursuant to Federal law at 42 CFR 455.23 the Division of TennCare may direct DentaQuest to suspend payments to a Provider where the Division of TennCare has made a determination that there is a credible allegation of fraud against the provider that is currently under investigation. In the event of such a suspension the Provider must work directly with the Division of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Division of TennCare.

6. **Other Program Integrity Actions**
   DentaQuest is required in its contract to report suspected cases of Provider fraud, waste, and abuse to TennCare, Office of Program Integrity (OPI),

and TBI MFCD. In addition, TennCare conducts its own independent Program Integrity functions. In a provider is contacted by the Division of TennCare concerning a Program Integrity matter, the Provider must work directly with the Division of TennCare to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Division of TennCare.

7. **TennCare, DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCD, Tennessee Attorney General and DOJ, as well as any authorized state or federal agency or entity, shall have the right to evaluate through inspection, evaluation, review, or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including, but not limited to, medical records and billing records.** When requested, the evaluation, inspection, review, or request, shall be performed with the immediate cooperation of the provider. The provider shall assist in such reviews, including the provision of complete copies of medical records. Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not bar disclosure of protected health information (PHI) to health oversight agencies so long as these agencies operate in compliance with applicable regulations. Any authorized state or federal agency or entity, including, but not limited to, TennCare, OIG, TBI MFCD, Tennessee Attorney General, DHHS OIG, DOJ, and the Office of the Comptroller of the Treasury may use these records and information for administrative, civil, or criminal investigations and prosecutions within the limitations set forth under HIPAA and Health Information Technology for Economic and Clinical Health (HITECH). Said records are to be provided by the provider at no cost to the requesting agency.

   The following statement shall be clearly posted in all facilities performing services to TennCare enrollees:
   "To report fraud or abuse to the Office of Inspector General you can call toll-free 1-800-433-3982 or go online to https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. To report provider fraud or patient abuse to the Medicaid Fraud Control Division, call toll-free 1-800-433-5454."

9.00 Quality Management Program (QIP) (policies 200 Series)

DentaQuest maintains a comprehensive Quality Management Program to objectively monitor and systematically evaluate the care and service provided to Members. The program is modeled after National Committee for Quality Assurance (NCQA) standards; the NCQA standards are adhered to as the standards apply to dental managed care. Additionally, DentaQuest's Quality Management Program is in compliance with the TennCare Dental Program guidelines. The scope and content of the program reflects the demographic and epidemiological needs of the population served.

DentaQuest uses the results of QMP activities to improve the quality of dental health in association with appropriate input from providers and Members. The evaluation of the QMP addresses Quality Monitoring studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. This quality survey will be released annually to the provider network. Each provider will get specific notification.

The Quality Management Program includes:

- Provider Credentialing and Recredentialing
- Member Satisfaction Surveys
- Provider Satisfaction Surveys
- Random Chart Audits
- Member Appeal Monitoring and Trending
- Peer Review Process
- Utilization Management and Practice Patterns
- Site Reviews and Dental Record Reviews
- Patient Safety
- Service Initiatives
- Compliance Monitoring
- Quarterly Quality Indicator Tracking (i.e. Member appeal rate, appointment waiting time, access to care, etc.)

The QMP includes both improvement and monitoring aspects, and requires the ongoing process of:

- Responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

- Assuring that the delivery of health care is appropriate, timely, accessible,

available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.

The QMP also includes written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not furnished.

DentaQuest maintains a comprehensive committee structure with oversight from the governing body to facilitate quality monitoring program activities.

Quality Monitoring Program Committee:

The purpose of the Quality Management Committee is to maintain quality as a cornerstone of the DentaQuest culture and to be an instrument of change through demonstrable improvement in care and service. The QMP Committee is accountable to DentaQuest's Governing Body, which approves the overall QMP, Work Plan, and Annual Evaluation. The Committee analyzes and evaluates the results of QMP activities, recommends policy decisions, ensures that providers are involved in the QMP, institutes needed action, and ensures that appropriate follow-up occurs.

Provider Peer Review Committee

DentaQuest maintains a Provider Peer Review Committee composed of dentists currently licensed in Tennessee and in good standing with the Tennessee Board of Dentistry. A participating TennCare Dental Provider is a member of this committee. This Committee meets regularly to review the processes, outcomes and appropriateness of dental care provided to members by participating providers.

A copy of DentaQuest's QMP is available upon request by contacting DentaQuest's Customer Service Department at 855.418.1623 or via e-mail at denelig.benefits@dentaquest.com.

10.00 Credentialing

DentaQuest has the sole right to determine which dentists (DDS or DMD) they shall accept and allow to continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, monitoring, 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.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry and is in full compliance with TennCare[SM] guidelines.

Nothing in this Credentialing Plan limits DentaQuest's discretion to accept or 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.
DentaQuest must credential each provider location and DentaQuest is not required to credential all of a provider's locations.

DentaQuest has the final decision-making power regarding network participation. DentaQuest will notify TennCare[SM] of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendation.
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.

Recredentialing

Network Providers are recredentialed at least every 36 months pursuant to TennCare[SM] guidelines.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 888.554.5542 or via e-mail at denelig.benefits@dentaquest.com

11.00 The Patient Record

Participating Providers are required to maintain proper patient records.

11.01 Accessibility and availability of Dental Records

Corrections/Alteration Protocols:
There are times when it is necessary to make a correction to a patient record; this need to make corrections should be an exception not a pattern. Any corrections, late entries, entries made out of sequence, and addenda made in a patient record should be clearly marked as such in the record. A single line should be drawn through any erroneous chart entry and the word “error” should be noted; the correct treatment should be noted with the correct treatment referenced and these corrections should be signed and dated. In incidents where correction or alterations would need to be completed on a later date, the addenda and/or corrected treatment information should be entered “chronologically and refer to the date of visit in question

According to the American Dental Association Council on Dental Practice Division of Legal Affair publication” Dental Records” published in 2010:

- Cross out the wrong entry with a thin line and make the appropriate change
- Date and initial each change or addition
- Never obliterate an entry with markers or white-out, as you and/or a third party must be able to read the wrong entry
- Do not leave blank lines between entries
- Do not insert words or phrases in an entry
- If a correction needs to be made at a later date, enter the correction chronologically but reference the date in question that you are correcting.

According to CMS Program Integrity:

Any record that contains delayed entries, amendments, corrections, or addenda must:

- Clearly and permanently identify any amendment, correction, or delayed entry as such; and
- Clearly indicate the date and author of any amendment, correction, or delayed entry, and
- Not delete but instead clearly identify all original content.”
- Corrections, amendments or delayed “entries to paper records must be clearly signed and dated upon entry in the record.”

11.02 Recordkeeping

Dental records may be on paper or electronic media. DentaQuest requires that dental records be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

Dental Record Standards – DentaQuest sets standards for dental records. These

standards shall, at a minimum, include requirements for:

a. Member Identification Information - Each page in the record contains the patient's name or member ID number.
b. Personal/biographical Data - Personal/biographical data includes: age; gender; address; employer; home and work telephone numbers; and marital status.
c. Entries - All entries are dated on the day of service. Entries shall detail services provided and be signed by the rendering provider
d. Provider Identification - All entries are identified as to author.
e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.
f. List of current medications.
g. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location.
h. Past Medical History - (for Members seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For orthodontics requested secondary to speech pathology, obtain speech/language records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency.
i. Diagnostic information.
j. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.
k. Tobacco Use - (For Members 12 years and over and seen three or more times) Notation concerning tobacco use is present. Abbreviations and symbols may be appropriate.
l. Referrals and Results Thereof.
m. Emergency Care.
n. Compliance with Tennessee Board of Dentistry Rule 0460-02-.12 regarding record keeping standards
o. Substance abuse and mental health treatment information (behavioral health records) – Records shall be kept separate and apart from the medical record in compliance with federal law.

Patient Visit Data – Documentation of individual encounters must provide adequate evidence of, at a minimum:

a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.
b. Plan of Treatment.
c. Diagnostic Tests.
d. Therapies and other Prescribed Regimens.
e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
f. Consultations, Referrals and Specialist Reports - Notes from any consult\ations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation

and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include

supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment.

g. All Other Aspects of Patient Care, Including Adjunctive Services.
h. Detailed documentation of sedation services provided including type of sedation, the amount, duration and list of drugs used, evidence of continuous patient monitoring and post-sedation recovery status (please see section 14.07).

Record Review Process

a. DentaQuest has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.
b. The record assessment system addresses documentation of the items listed in the Patient Visit Data section above.

12.00 Patient Recall System Requirement

Participating Providers are required to maintain proper patient records.

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 TennCare Dental Program Member that has sought dental treatment.

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that TennCare Dental Members sometimes fail to show up for dental appointments. DentaQuest offers the following suggestions to decrease the "no show" rate. Please note that Members cannot be charged for missed appointments.

- 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.
- Have the Member contact the provider's office prior to the appointment to confirm the time and place of the appointment.

B. Office Compliance Verification Procedures

DentaQuest will measure compliance with the requirement to maintain a patient recall system. Participating Providers are expected to meet minimum standards regarding appointment availability:

- Emergency care must be appointed within 24 hours and is defined as an unscheduled episode that requires a service to patients who present for immediate attention. The condition, if untreated, could place the patient's health in jeopardy.
- Urgent care, those involving pain, infection, swelling and/or traumatic injury, must be available within 48 hours.
    - DentaQuest ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the

member's treating dentist, other dental professional, primary care provider or triage nurse who is trained in dental care and oral healthcare. Initial and recall routine treatment must be scheduled within 21 days of initial contact with the dentist's office.

- Follow-up appointments must be scheduled within 21 days of the present treatment date. DentaQuest requires that a patient be seen within 45 minutes of arriving at the office or be given the opportunity to reappoint.
- Participating Providers unable to meet these guidelines must refer the Member back to DentaQuest. DentaQuest will then be responsible for arranging needed care in the appropriate time frames. The number for TennCare Dental Program Members to call for assistance is: 855.418.1622.

13.00 Radiology Requirements

DentaQuest recommends that you submit your attachments and x-rays through an electronic attachment service.

When mailing x-rays for authorization with the claim, **ALWAYS SUBMIT AN APPROPRIATELY LABELED DIAGNOSTIC QUALITY DUPLICATE OF THE X-RAY**. X-rays **WILL NOT** be returned unless a stamped, self-address envelope is attached to the request.

Guidelines for Prescribing Dental Radiographs

Type of Encounter	Adult Dentition or Partially Edentulous	Adult, Edentulous
New Patient being evaluatedfor dental diseases and dental development *	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a historyof extensive dental treatment.	Individualized radiographic exam, based on clinical signs and symptoms.
**Recall patient*with clinical caries or at increased riskfor caries ** **	Posterior bitewing exam at 6-18 month intervals	Not applicable
**Recall patient* with no clinical caries and not at increased risk for caries ** **	Posterior bitewing exam at 24- 36 month intervals	Not applicable
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecificgingivitis) can be identified clinically.	Not applicable
Patient for monitoring ofgrowth and development	Usually not indicated	

Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/ endo dontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluationand/or monitoring in these circumstances.

14.00 Clinical Criteria

For all procedures, every provider in the DentaQuest program is subject to random chart/treatment audits. These audits may occur in the Provider's office as well as in the office of DentaQuest. Based on the findings of any audit, the Provider will be notified of the results of the audit. In the event that audit findings require examination by the DentaQuest Tennessee Peer Review Committee, any requested records must be made available upon request to DentaQuest

Whether a procedure requires prior authorization or not, all procedures require that acceptable documentation standards be met. Documentation for all procedures rendered must justify the need for the procedure performed due to medical necessity, guided by a comprehensive, holistic approach to achieve optimal oral-systemic health.

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology, caries or destruction to tooth, supporting and related structures where treatment is being requested is required. *Postoperative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care*. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Failure to provide the required documentation, unsatisfactory chart audit results, or the failure to maintain acceptable practice standard 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. Additionally, the provider may be referred to the Division of TennCare for possible actions impacting the provider's ability to participate in Adult Dental, ECF CHOICES, 1915(c) Waiver, TennCare, CoverKids and other state Medicaid programs.

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 cast or milled restorations crowns is the cementation date. The completion date for endodontic treatment is the date the canals are permanently filled.

Providers participating in the Division of TennCare networks with DentaQuest represent and warrant that all dental services shall be provided in a high-quality manner and on a timely basis. Using the proper skill set, training and background necessary to accomplish medically necessary treatment, rendered by competent providers who possess the skills necessary to perform the services with the degree of skill and care that is required by current good and sound procedures and practices in accordance with industry standards. Upon member request, if a treatment requires the provider to retreat due to quality, the expectation is the provider will do this as part of their standard office policies.

Any reimbursement already made for an inappropriate or poor-quality service may be recouped after the DentaQuest Consultant reviews the circumstances. All covered dental services must also be Medically Necessary as defined by TennCare Rules. The clinical criteria presented in Section 14.01 through 14.11 are the criteria that DentaQuest dental benefit reviewers will use for making medical necessity determinations for those specific

procedures. In addition, please review the general benefit limitations for certain dental procedures presented in Exhibit A. Exceptions to general benefit limitations may be made on an individual member basis if medically necessary.

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

Please FAX this to 262-241-7150.
DentaQuest will process emergency authorization requests as high priority. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

14.01 Clinical Guidance: Adult Program

Adult oral health is important as untreated oral disease can have serious adverse health impacts. Untreated oral health problems can affect appetite and the ability to eat, or lead to tooth loss, all of which can lead, in turn, to nutritional problems. Untreated dental problems can also cause chronic pain that can affect daily activities such as speech or sleep. Oral health problems can also interfere with work. Employed adults are estimated to lose more than 164 million hours of work annually due to oral health problems. Research has also identified associations between chronic oral infections and diabetes, heart and lung disease, stroke and poor birth outcomes.

Although good oral health can be achieved through preventative care, regular at home self-care and the early detection, treatment and management of dental problems, it can positively impact overall health and the quality of life.

Oral Disease Risk and Dental Care Goals

The spectrum of aging requires different considerations throughout various stages of life. However, prevention and oral health and hygiene education is beneficial and should be employed for all ages. The major risks for partial and complete tooth loss in the adult population are caries and periodontitis which may increase with age due to decreased salivary production, periodontal disease, root caries and physical limitations such as poor vision, cognitive problems, mobility issues, decreased coordination and chronic disease that can reduce the effectiveness of brushing and flossing; mobility issues can often result in fewer dental care visits. These factors should be taken into consideration and addressed while treatment planning cases.

The periodicity for comprehensive oral examinations including oral cancer screening is one visit per year. Elimination of pain, infection, irritation, and the restoration of health to the oral cavity are the main goals of dental care throughout the adult years. Addressing coronal and root caries by preventing caries growth, formation and spread will be key elements in caries management. Treatment of gingivitis and periodontal disease will also be key to dentition

retainment.

Leading with Prevention

Leading with prevention at encounters**,** and guiding patients to preventive treatment strategies that can avoid emergency unplanned visits - has the potential to increase patient acceptance rates, patient satisfaction, and loyalty. By demonstrating that you and your team are invested in a patient's overall health rather than just numbers, patients are more likely to see the value of the treatment plan that you suggest.

Chronic Conditions and Oral Health

Having a chronic disease, such as arthritis, heart disease or stroke, diabetes, emphysema/ COPD, hepatitis C, obesity may increase an individual's risk of having missing teeth and poor oral health. Patients with weakened immune systems, such as those with HIV and other medical conditions (organ transplants) and those use certain medications (e.g. steroids) are at higher risk for some oral problems.

Common chronic diseases and conditions to be aware of in the adult population that affect oral health and care include but are not limited to: diabetes, tobacco use, oral cancer, chemotherapy, decreased salivary flow, hypertension and heart disease.

Research has shown that there is a synergistic relationship between oral health and overall wellness. Periodontal disease is linked to a host of illnesses including heart disease, osteoporosis and rheumatoid arthritis. Research has found that people with gum disease are twice as likely to die from a heart attack and three times as likely to have a stroke.

A thorough understanding of the effects of the patient's medical conditions and prescribed medications is advised. Consultation and collaboration with the patient's primary care physician is advised when necessary to aid in the formulation and implementation of the care plan for the patient.

DentaQuest encourages provider education to members on the importance of regular oral cancer screenings, particularly for patients with risk factors such as tobacco use, HPV (Human Papilloma Virus), alcohol use, chronic mucosal irritation and poor nutrition.

Patient Respect and Understanding

Respect for the needs and preferences of adult patients is of the utmost importance regardless of their age. It is imperative to always ensure that patients understand the information that is being presented prior to making treatment decisions. This is especially important for elderly patients and patients in which English is their second language. The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

https://health.gov/our-work/national-health-initiatives/health-literacy

https://health.gov/our-work/national-health-initiatives/health-literacy/consumer-health-content/myhealthfinder

Improve Health Services in the Community

The TennCare Adult Dental Program has the potential to significantly impact and turnaround the oral health of individuals in all local Tennessee communities. By accepting patients and providing culturally and linguistically appropriate care for patients in the Adult Dental Program, you are improving the oral health of the community while helping those in need.

References

www.cdc.gov/oralhealth/fast-facts/index.html

www.health.harvard.edu/diseases-and-conditions/gum-disease-and-the-connection-to-heart-disease

www.nidcr.nih.gov/health-info/diabetes

https://www.cdc.gov/oralhealth/basics/adult-oral-health/adult_older.htm

www.cdc.gov/oralhealth/basics/adult-oral-health/tips.html

www.nidcr.nih.gov/sites/default/files/2020-06/chemotherapy-and-your-mouth.pdf#:~:text=Chemotherapy%20Affect%20the%20Mouth%3F%20Chemotherapy%20is%20the%20use,mouth%3B%20and%20the%20glands%20that%20make%20saliva%20%28spit%29.

https://hpi.georgetown.edu/oralhealth/

14.02 Clinical Guidance: Pregnant & Postpartum Members

The oral health of pregnant and postpartum women can affect their health and mortality, the birth outcome of their unborn child as well the caries status of their infant. Hence the maintenance of optimal oral health is essential in this population. **Oral health care is safe and essential throughout all stages of pregnancy.** The following guidance will assure the appropriate management of the pregnant and postpartum patient.

Assess Pregnant and Postpartum Women's Oral Health Status

1.) Take an oral health history that inquires about the most recent dental visit, if they are in any pain, swelling or bleeding in the mouth, gestational age, if there are questions/concerns about receiving dental care while pregnant or in her postpartum period, if she has been experiencing morning sickness/ vomiting occurrences, and if she is currently receiving prenatal or postpartum care.
2.) Review medical history, dietary history, social history i.e tobacco, alcohol, and recreational drug usage.

3.) Perform comprehensive oral examination including a caries risk assessment and periodontal screening examination.
4.) Take radiographs to evaluate and diagnose oral diseases and conditions.

Advise and Educate Pregnant Women About Oral Health Care During Pregnancy and Postpartum

Reassure women that oral health care, including use of radiographs, pain medication, and local anesthesia, is safe throughout pregnancy and the postpartum period. Encourage women to continue to seek oral health care, practice good oral hygiene, eat healthy foods, and attend prenatal classes during pregnancy and the postpartum period.

Collaborate with Pregnancy and Postpartum Healthcare Professionals

Establish relationships with prenatal healthcare professionals in the community and develop a formal referral process. Coordinate care with prenatal health care professionals as appropriate. Consult with prenatal healthcare professionals when considering the following:

- Comorbid conditions that may affect the management of oral conditions (e.g., diabetes, hypertension, pulmonary disease, cardiac disease, bleeding disorders)
- The use of intravenous sedation or general anesthesia
- The use of nitrous oxide as an adjunctive analgesic to local anesthesia

Oral Disease Management and Treatment of Pregnant and Postpartum Women

- Provide preventative, emergency, or acute care during the pregnancy and postpartum as indicated.
- Develop, discuss, and provide a plan of care that includes prevention, dental treatment and maintenance throughout pregnancy and the postpartum period.
- Discuss benefits and risks of treatment and alternatives to treatments.
- Use standard practice when placing restorative materials such as amalgam and composite.
- Use a rubber dam during endodontic procedures and restorative procedures.
- Position pregnant patient appropriately during care:
    - Maintain the head at a higher level than her feet.
    - Place patient in a semi- reclining position, as tolerated, and allow frequent position changes.
    - Place a small pillow under the right hip, or have the patient turn slightly to the left as needed to avoid dizziness or nausea resulting from hypotension.
- Follow up with the patient to determine whether preventive and restorative treatment has been effective.
- Lactation concerns regarding medication interactions should be addressed to the PCP by the DDS via a consultation form.

Provide Support Services to Pregnant and Postpartum Women

If a pregnant or postpartum member presents to a dental office, requesting a dental appointment but does not show up as eligible for pregnancy dental benefits, please assist the member with the update, if possible, by sharing the instructions in Appendix A entitled “How to Add a Pregnancy for Existing Members” and/or share the following phone number with the member so that she may call and update TennCare Connect herself at 855-259-0701. It typically takes 48 hours after attesting for the member to show up as eligible. If the member does not have a prenatal healthcare professional, explain the importance of dental care, and facilitate referrals to prenatal healthcare professionals in the community that are in the TennCare Provider Network.

Improve Health Services in the Community

- Accept pregnant and postpartum patients enrolled in TennCare Program and provide culturally and linguistically appropriate care.
- Establish partnerships with community-based programs that serve pregnant and postpartum women.
- Provide referrals for nutritional counseling as needed.

Pharmacological Considerations and Guidance for Pregnant and Postpartum Women
Please refer to member’s obstetrician for pharmacological guidance.

References
https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/pregnancy#.Yadsgdd7J-c.link

https://www.mchoralhealth.org/PDFs/Oralhealthpregnancyconsensusmeetingsummary.pdf

https://scdhec.gov/sites/default/files/Library/CR-009437.pdf

14.03 Clinical Guidance ECF CHOICES / IDD Programs

Preventive Management Guidance for Patients with Special Health Care Needs (SHCN)

Individuals with SHCN may be at increased risk for oral diseases; these diseases further jeopardize the patient’s health. Education of parents/caregivers is critical for ensuring appropriate and regular supervision of daily oral hygiene. The ECF or 1915(c) Waiver dental provider team of dental professionals should develop an individualized oral hygiene program that takes into account the unique disability of the patient. Brushing with a fluoridated dentifrice twice daily should be emphasized to help prevent caries and gingivitis. If a patient’s sensory issues cause the taste or texture of fluoridated toothpaste to be intolerable, a fluoridated mouth rinse may be applied with the toothbrush. Toothbrushes can be modified to enable individuals with physical disabilities to brush their own teeth. Electric toothbrushes and floss holders may improve patient compliance. Caregivers should provide the appropriate oral care when the patient is unable to do so adequately.

A non-cariogenic diet should be discussed for long term prevention of dental disease.

When a diet rich in carbohydrates is medically necessary (e.g., to increase weight gain), the dentist should provide strategies to mitigate the caries risk by altering frequency of and/or increasing preventive measures. As well, other oral side effects (e.g., xerostomia, gingival overgrowth) of medications should be reviewed.

Though sealants are not covered by TennCare, we feel it is important to note that patients with SHCN may benefit from sealants. Sealants reduce the risk of caries in susceptible pits and fissures of primary and permanent teeth. You may want to discuss with your SHCN patients and/or their representatives that sealants are not TennCare covered services and whether they would like to pay out of pocket for sealants. Topical fluorides may be indicated when caries risk is increased. Interim caries arresting medicament Silver Diamine Fluoride (SDF) is particularly useful in managing caries in patients with SHCN. Interim therapeutic restoration (ITR), using materials such as glass ionomers that release fluoride, may be useful as both preventive and therapeutic approaches in patients with SHCN. In cases of gingivitis and periodontal disease, chlorhexidine mouthwash used as an oral rinse or to apply the chlorhexidine to a toothbrush. Patients having severe dental disease may need to be seen every two to three months or more often if indicated. Those patients with progressive periodontal disease should be referred to a periodontist for evaluation and treatment.

D9920 Behavior Management

The following frequency limitations will apply to the use of D9920:

- Four 15-minute units of D9920 per day per patient, reimbursed per unit
- Patient record must indicate the additional staffing required to complete the treatment
- Patient record must indicate the type and/or types of behavior management techniques used
- D9920 **can be** used in conjunction with D9230 on the same date of service
- D9920 **cannot be** used in conjunction with D9223, D9243 and/or D9248 on the same date of service

DentaQuest does not reimburse for behavior management if:

1. Billed routinely every time the recipient visits the office; or
2. Billed with sedation, excluding inhalation sedation (nitrous oxide anxiolysis), on the same date of service.

As with all waiver-only dental services, this code requires prior authorization.
Prior authorization documentation will require the following:

1.) Narrative of medical necessity is present
2.) Narrative clearly describes the member's mental, physical, or developmental illness/disability (stating “ECF” or Department of Intellectual and Developmental Disabilities(DIDD) member is not acceptable)
3.) Narrative describes previous attempts at treatment - must indicate that there were attempts and description of what occurred during attempts.
4.) Narrative is not generic and is specific to the individual member.

Examples of **unacceptable** narratives:

This patient presents for dental treatment in a highly anxious state and physically resisting necessary dental treatment. Behavior Management in the form of a papoose board

is necessary to provide safe, effective, and quality treatment for this patient.

This patient presents with his or her legal guardian for needed and mutually agreed upon dental treatment. Due to the patient age developmental status and inability to safely tolerate dental treatment it was necessary to utilize protective stabilization.

D9997 Case Management for Members with Special Healthcare Needs

It is essential to obtain an accurate medical history as well as a medical clearance for dental care. An evaluation for pre-existing medical conditions must be performed before any therapeutic measures are begun. Because patients may be living apart from family, obtaining the history may require collating information from multiple sources. Patients who live at home with parents/family often have had ongoing medical care from physicians with whom the family has developed a close relationship. In that case, obtaining accurate information is easier because there is continuity. When patients are living in group homes or with a sponsor, the individual who is transporting the patient to the dental office often has little or no information concerning the patient. Acquiring information from primary sources is critical to ensure accuracy. Patients residing in group home settings often have a medical journal that is brought to each dental visit. Copies of the annual physical, current medications, and recent consultations provided are an excellent resource for the dentist to obtain an accurate medical history, precautions and contraindications as it relates to potential treatments and sedations, medication reconciliation, and list of current medical providers.

It is imperative to have an accurate caries risk assessment along with periodontal risk to help justify the need for supplemental appointments that support a prevention-based program to improve the patient's health. By doing this, we can avoid premature and unnecessary extractions and improve the patient's quality of health and life. With minimally invasive techniques such as Silver Diamine Fluoride, partial caries removal and remineralization strategies, we can help reduce rates of active caries, the need for extensive dentistry and in some cases, reduce the need for sedation or hospital dentistry.

D9997 Dental Case Management- Patients w/ Special Healthcare Needs (SHCN)
Special treatment considerations for patients/individuals with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services.

The Dental Case Management visit allows the provider to interact with the patient and observe the patient's responses and abilities. It also allows for the procurement of pertinent information and assessments from the dental provider and other treating healthcare providers. This assessment visit should ultimately inform the course and direction of the treatment and care plan for the patient. According to the ADA, knowing the patient's living situation and understanding their chain of communication can be the difference between treatment success or failure. This information can also open the door to inquiring about other services that may be available to your Special Healthcare Needs patients.

The fees for the Dental Case Management visit for patients with special health care needs are considered largely administrative and used to identify and plan for services that will be needed to deliver Oral Health Care services to patients with Special Healthcare Needs designation i.e. ECF and DIDD /IDD Program patients. These services are not billable to the patient.

D9997 Dental Case Management Code Billing & Pre-Authorization Requirements

- For pre-authorization requests for D9997, a statement of need with medical diagnosis submission is required for pre-authorization of this code.
- For claim billing for D9997, two forms are required to be submitted as documentation with the claim form.

The forms required to be submitted with the claim and kept in the chart are below. A copy of these forms can be found in the Index of this manual.

- Dental Case Management Form for Patients with Special Healthcare Needs
- Medical Clearance & Sedation Clearance Form for Patients with Special Healthcare Needs

The following frequency limitations will apply to the use of D9997:

- This benefit is allowed once per provider per patient per lifetime.
- Patient record must indclude the above form

14.04 Criteria for Dental Extractions

Although all extractions must be medically necessary, not all procedures require authorization. Extraction of permanent teeth in individuals do not require authorization. Unerupted third molars require prior authorization for ECF CHOICES/1915(c) Waiver members. However, unerupted third molars are not a covered benefit in the Adult Program unless they are soft tissue impacted or residual tooth roots to be surgically removed.

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

Documentation needed for authorization procedure:

Diagnostic radiographs (strongly encourage digital) that are labeled Right (R) and Left (L) and the date the radiographs were taken showing clearly the adjacent and opposing teeth submitted for authorization (whether prior or post service) review; bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when prior-authorization (authorization prior to service) is not possible, will still require that appropriate radiographs be submitted with the claim for review for payment. This is considered retro-authorization.

Authorization for extraction of soft tissue impacted third molars in the Adult Program and unerupted third molars in the ECF CHOICES/1915(c) Waiver

Program:

Benefit review decisions for the authorization of unerupted third molar extractions will be based upon medical necessity. In other words, **providers must use the most current and appropriate ADA Code(s) on Dental Procedures and Nomenclature (CDT) when submitting either a prior- authorization or retro-authorization for unerupted third molar extractions.**

- The prophylactic removal of disease-free un-erupted third molars is not considered medically necessary and, therefore, will not be authorized.
- Impaction alone, absent pathology does not meet medical necessity criteria and therefore will not be authorized.
- For an extraction to be considered medically necessary an un-erupted third molar must show pathology, or
- An un-erupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations **and** substantial (> 50%) root formation.
- Discomfort from natural tooth eruption not caused by pathology or an aberrant tooth position will not qualify an un-erupted third molar extraction for authorization.
- When at least a single third molar meets the criteria above, the DBM may, at its complete clinical discretion and on a case-by-case basis, approve the extraction of additional un-erupted third molar teeth to avoid risk from multiple exposures of the member to anesthesia.
- Routine incision and drainage is not considered a separate benefit if the extraction serves in this function.
- Tooth re-implantation:
    - Must include a narrative indicating accident or trauma
    - Must include a peri-apical radiograph
    - Can only be reviewed retrospectively

14.05 Criteria for Crowns

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth should be submitted for prior authorization or with the claim once service has been rendered (bitewings, periapicals or panorex.)
- Appropriate diagnostic radiographs showing the completed restoration must be in the patient’s record.

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

Extensive treatment plans including endodontics, implants, prosthodontics, or

multiple crowns may require a second opinion as determined by DentaQuest.

Documentation required post service:
Clinically accepted standards of care REQUIRE post cementation/insertion radiographic evidence that all crowns have been completed. A post insertion radiograph is not required to be submitted but must be in patient's chart, and the quality of the restoration must be able to be confirmed by the radiograph. If a provider chooses to submit a post cementation radiograph, it is important to note that no additional reimbursement is allowed for post cementation radiographs. Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.

Criteria:

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

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

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- A request for a build up or a cast core (only covered for ECF CHOICES/1915(c) Waiver members) must meet the following criteria:
- Presence of greater than 50% bone support
- Absence of sub-osseous decay and/or furcation involvement
- Absence of adequate tooth structure to support crown
- Clinically acceptable root canal fill

Please note that cast core and buildup are not covered services through the Adult Program

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

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown on the prepared tooth.

Crowns on permanent teeth are expected to last a minimum of five years.
Authorizations for crowns will not meet criteria if:

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent destruction due to caries or trauma.

14.06 Criteria for Endodontics

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted showing properly condensed/obturated canal(s), for review for payment.

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

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

Authorization for Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for root canal therapy, root canal re-treatment, apicoectomies and apexification as appropriate based on benefit guidelines in the ECF/1915(c) Waiver and Adult Dental Program will not meet criteria if:

- Gross periapical or periodontal disease is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- Filling material not accepted by the Federal Food and Drug Administration.

Other considerations:

- 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 DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

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

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

To meet criteria, a crown must be opposed by a tooth or denture or is an abutment for a partial denture.

- The patient must be free from active periodontal disease.
- The permanent tooth must be at least 50% supported in bone.

14.07 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU) (ECF CHOICES & 1915(c) Waiver Programs ONLY)

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In emergencies).

Providers must submit the following documents or review by DentaQuest for authorization of Operating Room cases:

- Provision of dental treatment in a hospital or SPU requires informed consent and documentation of consent in patient record.
- Provision of dental treatment in OR for SPU requires prior authorization from DentaQuest unless such dental treatment constitutes an emergency.
- An *emergency* is defined herein as a presenting condition where waiting for treatment could seriously jeopardize the member's life, physical health, or mental health or their ability to attain, regain, or maintain full function

Providers requesting PA for dental treatment in OR or SPU must submit the following documentation with their PA request in order for DentaQuest to determine whether the PA request meets medical necessity and clinical criteria:

- Completed TennCare Inpatient and Outpatient Hospital Readiness Preadmission Form. (See Appendix A-8 of this manual for required form.) This form must evidence that the requesting dental provider attempted to treat the patient in-office and, where appropriate, referred the patient to a pediatric dentist or other specialist. Absent evidence of attempted in-office

treatment and/or referral to pediatric dentist or other specialist, prior authorization may be denied by DentaQuest.

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

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

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

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

**Dental Records are regulated by the Rules of the Tennessee Board of Dentistry 0460-2-.11 Regulated Areas of Practice (5a and b).*

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

Criteria:

Sedation services are only provided based upon the documented medically necessary needs of the Member and not the convenience of either the member or the provider. Where sedation services may be appropriate include dental services for TennCare Dental Program Members:

a. Who are extremely uncooperative, fearful, anxious, unmanageable, or physically resistant and
b. Members whose dental needs are of such severity that treatment should not be postponed or deferred; and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity; and
c. For which dental treatment under local anesthesia, and other alternative adjunctive techniques and modalities have not been successful in producing a successful result and which, under general anesthesia, can be expected to produce a superior result.

In most situations, OR cases will be authorized for procedures covered by TennCare[SM] if the following is (are) involved:

- 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 precludes safely treating the member in the office environment.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

14.08 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.
Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

Criteria:

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

- A full or partial denture is determined to be an initial placement if the patient has never worn a prosthesis.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (full or partial dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

Initial specifications for fabrication of a removable partial prosthesis:

- Masticatory function must be severely impaired for a recipient to qualify for a removable partial denture.
- A removable partial denture shall replace a minimum of 3 to 4 permanent,

posterior teeth based on one of the following conditions:
    - A total of 4 posterior teeth in the arch **or**
    - A total of 3 adjacent posterior teeth in the arch
- Adequate and sufficient alveolar bone support of the remaining teeth in the arch is required; a minimum of 50% bone support is required.
- The overall restorability of the arch will be considered.
- Partial dentures are covered only for recipients with good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated caries or active periodontal disease the abutment teeth.

Authorizations for all removable prosthesis will not meet criteria:

- If there is an existing prosthesis which is not at least 5 years old and nonfunctional.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If the recipient cannot accommodate and properly maintain the prosthesis (lodge, gag reflex, potential for swallowing the prosthesis, severe disability).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or anatomical reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient.

Note: The addition of teeth and/or clasps to a partial denture **is** a covered benefit if the addition makes the denture functional.

Benefit Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion.
- 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.

When the first 6 months post - delivery has passed for both complete and partial dentures:

- Adjustments will be reimbursed at one per calendar year per denture.
- Repairs will be reimbursed at two repairs per denture per year.
- Relines will be reimbursed once per denture every 36 months.
- A new prosthesis will not be reimbursed within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
- Replacement of lost, stolen, or broken dentures less than 5 years of age will not meet criteria for pre-authorization of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a

new denture.

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

14.09 Criteria for the Excision of Bone Tissue

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

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

CDT codes D7320, D7321, D7471, D7472, and D7485 are related to the removal of exostoses. These codes are subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Authorization requirements:

- Appropriate radiographs and/or intra-oral photographs and/or study models which clearly identify the exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Copy of detailed treatment plan– including prosthetic plan.
- Narrative of medical necessity, if appropriate.

- Alveoloplasty in conjunction with extractions requires:
    - A minimum of 4 teeth removed in a quadrant to qualify for the code
    - Narrative supporting necessity for prosthetic placement. Treatment notes must indicate that an Alveoloplasty is a separate surgical procedure from tooth removal.

- Alveoloplasty not in conjunction with extractions requires:
    - A minimum of 4 tooth spaces in a quadrant to qualify for the code
    - Narrative supporting necessity for prosthetic placement
    - Not allowed with extractions in same quadrant on same date of service

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

Note: D7310 and D7311 are also covered codes when performed in conjunction with extractions.

The code description for alveoloplasty differs based on whether it is performed in

conjunction with extractions or without extractions. It also differs based on the number of teeth or tooth spaces that will be contoured.

Code D7310 is for alveoloplasty in conjunction with the extraction of 4 or more teeth or tooth spaces per quadrant; while code D7311 is for alveoloplasty in conjunction with 1 to 3 three teeth or tooth spaces per quadrant. These two codes are used as a corrective procedure when the alveoloplasty is a distinct surgical procedure from the extraction.

The alveoloplasty procedure helps to recreate the natural contour of the gums and alveolus that may have been lost due to bone loss that occurred as a result of the extraction, or other reason. The D7310/D7311 benefit per TennCare ORM is restricted to one per lifetime per quadrant and is not allowed with surgical extractions in the same quadrant. Pre- authorizations for dentures and partials should be submitted along with planned extractions for approval. When a valid request for prothesis is approved and extractions rendered, D7310/D7311 can be submitted on a separate authorization to facilitate denture delivery.

D7320 is the code for alveoloplasty not in conjunction with extractions for 4 or more teeth or tooth spaces per quadrant. D7321 is the code for alveoloplasty not in conjunction with extractions for 1 to 3 teeth or tooth spaces per quadrant. This procedure typically involves trimming jagged, irregular or undercut areas of the alveolar ridge. This procedure facilitates insertion and improves fit and comfort of the denture prosthesis. The D7320/D7321 benefit is restricted to one per lifetime per quadrant and does require prior approval per TennCare ORM. D7320/D7321 should be requested with extractions as long as there is not a valid approval for a removable denture prosthesis in the same arch history.

14.10 Criteria for the Determination of a Non-Restorable Tooth

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

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

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

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

14.11 Criteria for Periodontal Treatment

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. **Radiographs must be properly identified with the patient's name and date of birth, as well as labeled with proper left/right orientation.**

Documentation needed for authorization of procedure:

- Diagnostic radiographs – periapicals or bitewings preferred.
- Copy of detailed treatment plan
- Intra-oral photographs clearly identifying the condition in cases of gingival hyperplasia

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

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

Criteria:

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

14.12 Criteria for Use of Silver Diamine Fluoride (caries arresting medicament application)

DentaQuest, as a market leader in improving oral health, strongly supports the use of appropriate medically necessary diagnostic and preventive services. Consistent with that fundamental strategy, ADA CDT Code D1354 (Interim caries arresting medicament application) is a covered service.

DentaQuest and TennCare™ advocate that the clinical indication for the use of Silver Diamine Fluoride is the management and arresting of *significant areas* and frequency or numbers of carious lesions.

Administration of this benefit will be limited to four applications during member's total period of eligibility, and there is a **four-week** period after the last application that restorative treatment is not a covered service. This will assure the Silver Diamine Fluoride treatment and effect on the carious tooth structure has been able to approach desired completion.

After a four-week interim period for completion of reaction, restorative treatment for carious teeth, (based on medical necessity) will then be covered service(s).

SDF has been recommended for patients of any age for following reasons:

- Extreme caries risk including both coronal and root caries
- Behavioral or medical management challenges
- Numerous carious lesions that are not treatable in one operative visit
- Difficult to treat lesions
- No access to comprehensive care
- OR Diversion

15.00 General Definitions

The following definitions apply to this Office Reference Manual:

Adverse Benefit Determination– Adverse action affecting TennCare Dental Program Services or benefits as defined in 42cfr 438.400 shall mean, but it is not limited to, a delay, denial, reduction, suspension or termination of TennCare Dental Program dental benefits, as well as any other act or omission of the TennCare Dental Program which impairs the quality, timeliness, or availability of such benefits. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Agreement – The Provider Agreement between DentaQuest and Provider, including all attachments thereto.

Appeal Process – The process whereby a Member exercises their right to contest verbally or in writing any adverse action taken by DentaQuest to deny, reduce, terminate, delay or suspend a Covered Service as well as any other acts or omissions of DentaQuest which impair the quality, timeliness, or availability of such benefits. The appeal process shall be governed by Federal law at 42CFR 438.100 et seq. TennCare Dental Program rules, regulations and any and all applicable court orders and consent decrees. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Benefits – Shall mean the health care package of services developed by the Bureau of TennCare Dental Programs and which define the covered services available to the TennCare Dental Program members. The Agreement focuses on Dental benefits although Benefits provided by the Member's MCO are sometimes mentioned. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Division of TennCare - Shall mean the Tennessee Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare responsible for administering the TennCare Dental Programs.

CAQH – Shall mean "The Council for Affordable Quality Healthcare," a nonprofit alliance of health plans and trade associations, working to simplify the first steps of the provider credentialing and application data collection process.

Clean Claim – A claim received by DentaQuest for adjudication that requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by TennCare.

Contract or TennCare Dental Benefits Manager Contract - Shall mean the contract between TennCare and DentaQuest, identified as Edison Contract ID #36736, wherein DentaQuest contracted to be responsible for the financial, clinical and managerial aspects of the TennCare dental benefits management (DBM) program**.**

Covered Service – Shall mean dental services, benefit services and benefits that are Medically Necessary, including TennCare Dental Program services, and that satisfy all the

criteria

set forth in the TennCare Dental Program rules, policies, the Agreement, and in this Provider Office Reference Manual. ***See also TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Dental Benefits Manager (DBM) – Dental Benefits Manager shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to members in the TennCare Dental Programs to the extent such services are covered by TennCare***. See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13- 14-.01***

Dental Home – A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible and coordinated way.

DentaQuest - Shall refer to DentaQuest USA Insurance CO., LLC.

DentaQuest Service Area - Shall be defined as the State of Tennessee.

Disallowed – Procedures that are not paid benefits by TennCare Dental Programs are collectable from the TennCare Dental Member.

Emergency Medical Condition – Emergency Medical Condition, including emergency mental health and substance abuse emergency treatment services, shall mean the sudden and unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

- Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For Medicaid members only, copayments are not required for emergency services. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Emergency Services – Covered inpatient and outpatient Emergency Medical Condition services that are furnished by a Provider who is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

Member – Member shall mean an individual eligible for and enrolled in the TennCare Program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act.

Grievance – as defined in 42CFR438.100 is a Member's right to contest an action taken by the Contractor or service provider that does not meet the definition of an Adverse Benefit Determination.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Mandates the use of standards for the electronic exchange of health care data; to specify what

medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of individually identifiable health care information.

Health Information Technology for Economic and Clinical Health (**HITECH**) **Act** – Enacted to improve health care quality, safety and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information; to adopt an initial set of standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology; and to establish the capabilities and related standards that certified electronic health record technology (Certified HER Technology) shall need to include in order to, at a minimum, support the achievement of the proposed meaningful use by eligible professionals and eligible hospitals.

Managed Care Organization (MCO) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Dental Programs.
See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01

Medically Necessary is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute.
The term “medically necessary,” as defined by Tennessee Code Annotated, Section 71- 5-144, applies to TennCare Dental Program members. Implementation of the term “medically necessary” is provided for in the TennCare Dental Program rules, consistent with the statutory provisions, which control in case of ambiguity. No member shall be entitled to receive and the TennCare Dental Program shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.
See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01

Medical Necessity Determination – A decision made by the Chief Medical Officer of the Division of TennCare or his or her clinical designee or by the Medical Director of one of DentaQuest or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of Medical Necessity contained in Tennessee Code Annotated, Section 71-5-144 and these rules as defined herein. Items or services that are not determined medically necessary shall not be paid for by TennCare. ***See TennCare Rule 1200-13-13-.01, TennCare Rule 1200- 13-14-.01 and TennCare Rule 1200-13-16(32)***

Medical Necessity Guidelines/Clinical Criteria – Evidence-based guidelines approved by the Chief Medical Officer of the Division of TennCare for the purpose of guiding Medical Necessity determinations

Member - Shall mean a TennCare Dental Program Medicaid -eligible individual who is enrolled in a managed care organization. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Member Grievance - Shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does not meet the definition of Adverse Benefit Determination.

National Provider Identifier (NPI) – The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for Covered Health Care Providers. Covered Health Care Providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI must be used in lieu of Legacy Provider identifiers in the HIPAA standards transactions.

Non-covered Benefit/Services – Items and services that are not within the scope of defined benefits for which a beneficiary is eligible under TennCare, including cost-effective alternative services and medical items and services that are in excess of any applicable limits on such items or services that might otherwise be covered. With the exception of cost-effective alternative services, non-covered services under TennCare, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as “medically necessary”, regardless of the medical circumstances involved.

Non-participating Provider – Shall mean a DentaQuest dental provider who is not contracted as a DentaQuest Network Provider under the TennCare Dental Programs. ***See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01***

Provider or Participating Provider - Shall mean a TennCare provider, as defined herein and in the TennCare Rules, who has entered into a contract with the Dental Benefits Manager.

Protected Health Information (PHI) – Individually identifiable health information held or maintained by a covered entity or its business associates that is transmitted or maintained in any form or medium. This includes identifiable demographic and other information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information.

Provider/DentaQuest Office Reference Manual (ORM) – The manual provided that clearly defines TennCare Dental Program covered services, limitations, exclusions and utilization management procedures, including, but not limited to, prior approval requirements and special documentation requirements (hospital readiness form, orthodontic readiness form, documentation of nutritional problems [general pediatric records including growth data], speech/hearing evaluations [may include school records]) for treatment of members. The terms of the Provider Office Reference Manual are incorporated by reference into the DentaQuest Provider agreement. In the event of a discrepancy between the ORM and the TennCare Dental Program Rules, the TennCare Dental Program Rules shall apply.

Specialty Services – Includes Endodontic, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontics, and Prosthodontics.

State – State of Tennessee

TennCare– The program administrated by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Tennessee.
See TennCare Rule 1200-13-13-.01 and TennCare Rule 1200-13-14-.01

Unsecured PHI – Protected health information that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of DHHS.

16.00 Confidentiality and Safeguards

Provider acknowledges it is a covered entity under the HIPAA Rules and agrees to comply with all applicable HIPAA and HITECH (hereinafter "HIPAA/HITECH") Rules. In accordance with HIPAA/HITECH, Provider shall comply with requirements of HIPAA/HITECH including, but not limited to, the Transactions and Code Sets, Security, Breach Notification, and Privacy Rules.

A. **Transactions and Code Sets:** Provider shall comply with the requirements of 45 C.F.R. Part 162, the HIPAA Transactions Rule. Compliance includes conducting electronic transactions using all applicable data content and data conditions of adopted standards and, when required, using the applicable formats for adopted standards. Providers must require any entity that conducts such transactions on its behalf to comply with all applicable requirements of 45 C.F.R. Part 162 and to require any Subcontractor to comply with all applicable requirements of 45 C.F.R. Part 162.

B. **Security:** Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart C, the HIPAA Security Rule. Under the Security Rule, health care providers (and other covered entities) must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information and implement safeguards sufficient to reduce the identified risks and vulnerabilities to a reasonable and appropriate level.

C. Breach Notification: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart D, the HIPAA Breach Notification Rule. When required by the Breach Notification Rule, Provider shall notify applicable parties of a "breach" of unencrypted protected health information. In addition, Providers shall also notify DentaQuest immediately upon becoming aware of any provisional or actual breach as it relates solely to TPPOHP Dental Members.

D. Privacy: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart E, the HIPAA Privacy Rule. Among other things, the Privacy Rule requires a Provider to:

- Implement reasonable and appropriate safeguards to ensure that it uses and discloses Protected Health Information only for treatment, payment, health care operations, and other purposes permitted or required by the Privacy Rule.
- Establish appropriate mechanisms to limit the use or disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use or disclosure.
- Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, member rights and penalties upon hire and at appropriate intervals thereafter and maintain appropriate documentation of such training.
- Engage its business associates in business associate agreements that meet the requirements of the Privacy and Security Rules.

- Make Protected Health Information available in accordance with 45 C.F.R. § 164.524; amend Protected Health Information and incorporate any amendments as required by 45 C.F.R. § 164.526; and account for disclosures of patients' Protected Health Information as required by 45 C.F.R.
  § 164.528.
- Provide patients with a notice of privacy practices in the manner and with the content required by the Privacy Rule, including information that informs patients of their privacy rights.

17.00 Sensitive Information

Provider must comply with the following requirements with respect to certain sensitive information:

A. Alcohol and Drug Abuse Treatment Records: When Provider receives information subject to the Federal Substance Abuse Rule (42 C.F.R. Part 2), Provider must comply with 42 C.F.R. Part 2, which generally prohibits re-disclosure without written consent. Note that a general written consent (including a HIPAA-compliant authorization) is *not* sufficient. In most cases, the following statement will accompany these records and must be included with such records when Provider discloses them to another party:

> *This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

B. Federal Tax Information (FTI): Any FTI made available to Provider must be used only for the purpose of carrying out the provisions of this Agreement. Federal Tax Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of the Provider is strictly prohibited.

Failure to comply with federal regulations regarding SSA, Medicaid, CHIP, and Substance Abuse, FTI, and PHI data may result in criminal and civil fines and penalties.

APPENDIX A – ADDITIONAL RESOURCES

Welcome to the DentaQuest provider forms and attachment resource page. Offices have the option to use clinical forms as a template for office forms. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at DentaQuest.com Once you have entered the website, click on 'Tennessee' and then go to "Provider Resource Documents" to access the following resources:

Adult Dental and Pregnancy Specific Forms:

- How to Add a Pregnancy for Existing Members
- Comprehensive Medical Consultation Form
- Dental Care Referral Form
- Emergency Medical Clearance Form

TennCare Specific Forms:

- Outpatient Hospital Readiness Form
- Provider Post Service Appeal Form
- Dental Member Appeal Form
- Member Unfair Treatment Complaint Forms
- Member Agreement to Pay Non-Covered Treatment

DentaQuest General Forms:

- Dental Claim Form
- Clinical Exam Form
- Authorization for Dental Treatment
- Health History Form
- Provider Update Form
- Request for Transfer of Records
- Patient Refusal of Recommended Treatment
- Dental Case Management form for Patients with Special Healthcare Needs
- Medical Clearance & Sedation Clearance Form for Patients with Special Healthcare Needs

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 855.418.1623.

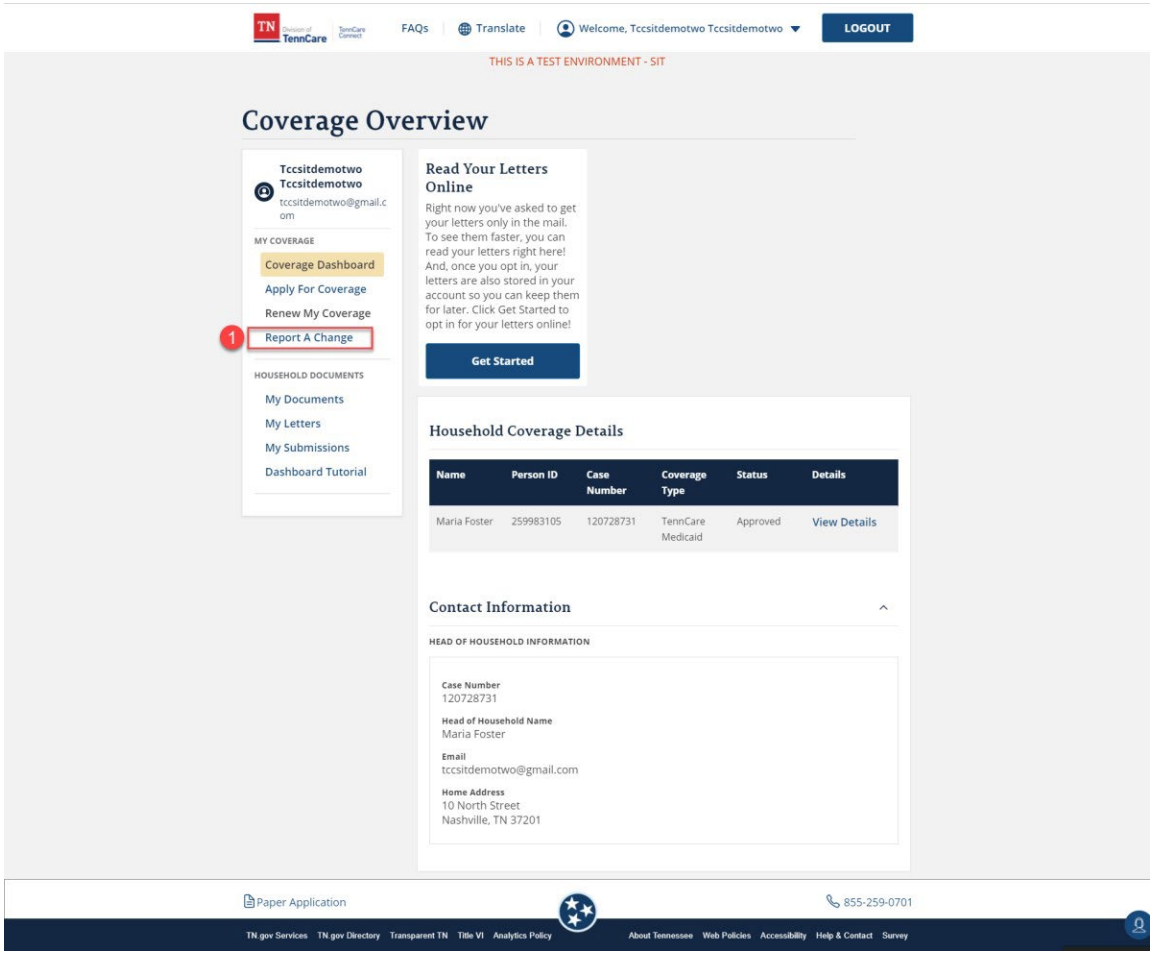
You may also find copies of these forms within this manual.

How to Add a Pregnancy for Existing Members

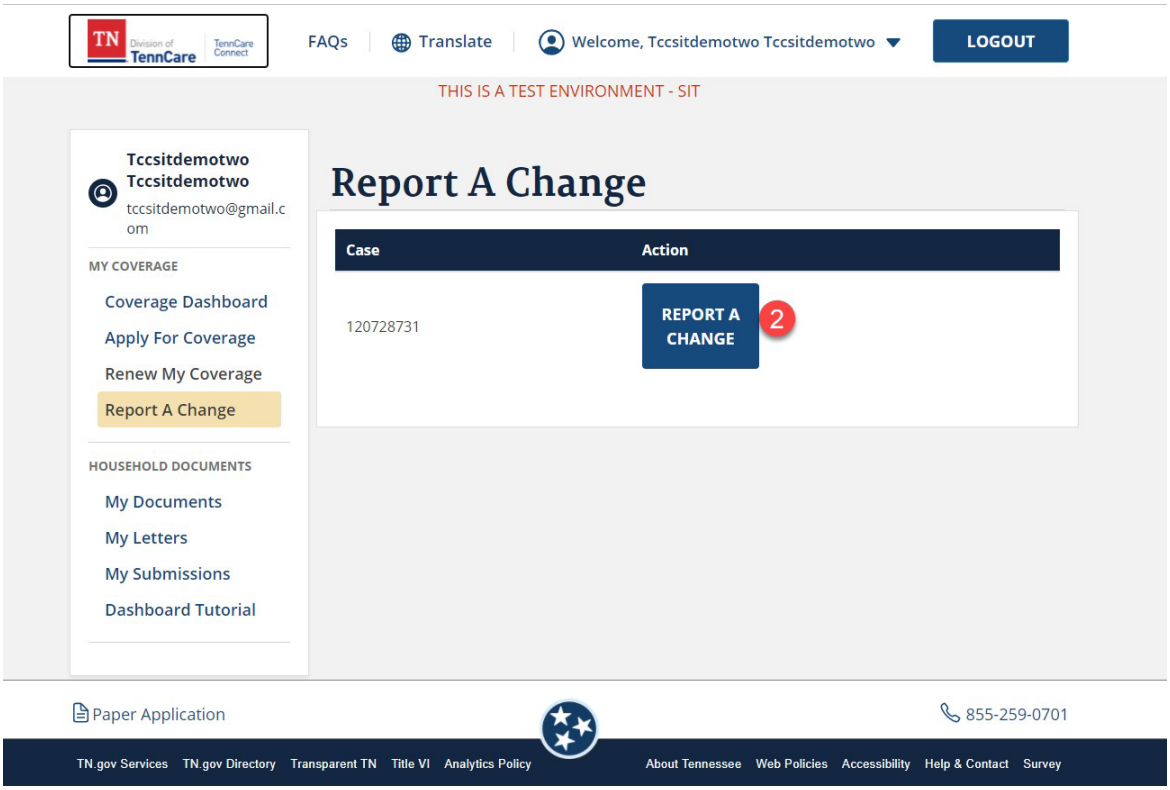
Sample case: Case has two individuals: Maria Foster is the mother of Carry Foster and doesn't have anypreviously reported pregnancies on file.

As you log in, it will take you to the **Coverage Overview** screen. Here, you can review coverage detailsand contact information for the case.

Step 1: From the left panel, navigate to the **Report A Change** hyperlink



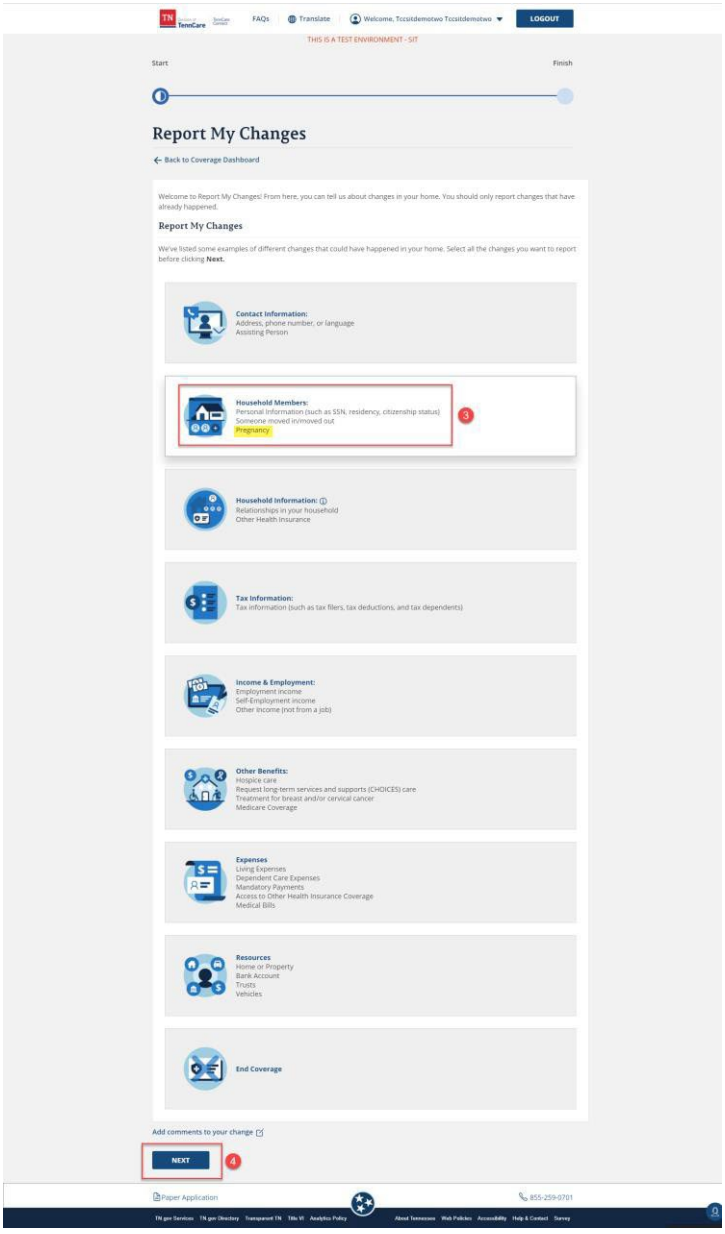
Step 2: Navigate to this screen and click on the **Report a Change** button alongside the case numberlinked to the Member Portal account



Step 3: As you click on the **Report A Change** button, you will be navigated to the **Report My Changes**
gatepost screen.

The screen displays separate tiles for the different changes one can report.

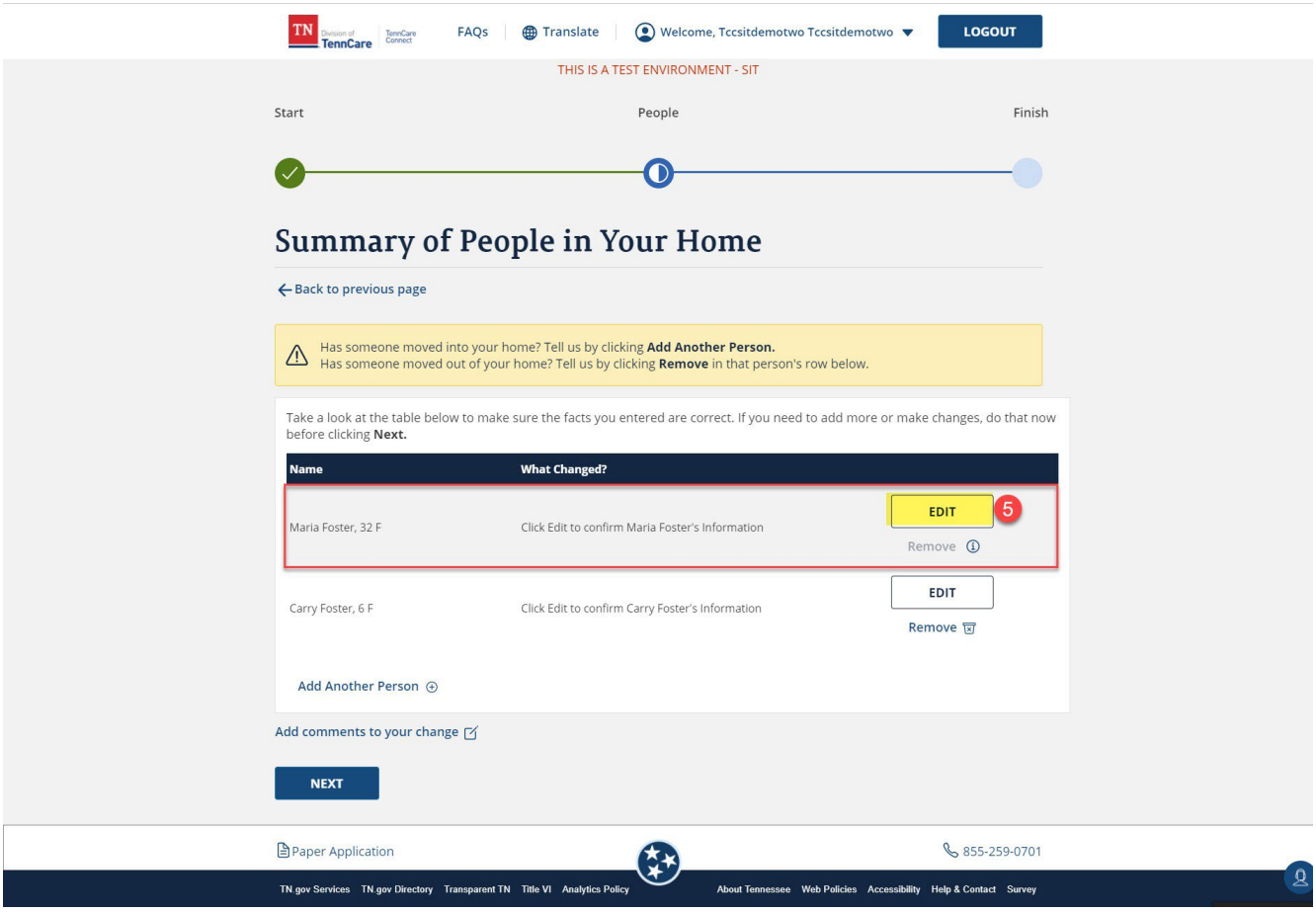
In order to **add a pregnancy** for an existing individual, click on the red-outlined tile which will take youto the **People In Your Home** module, wherein the **Pregnancy** section resides.



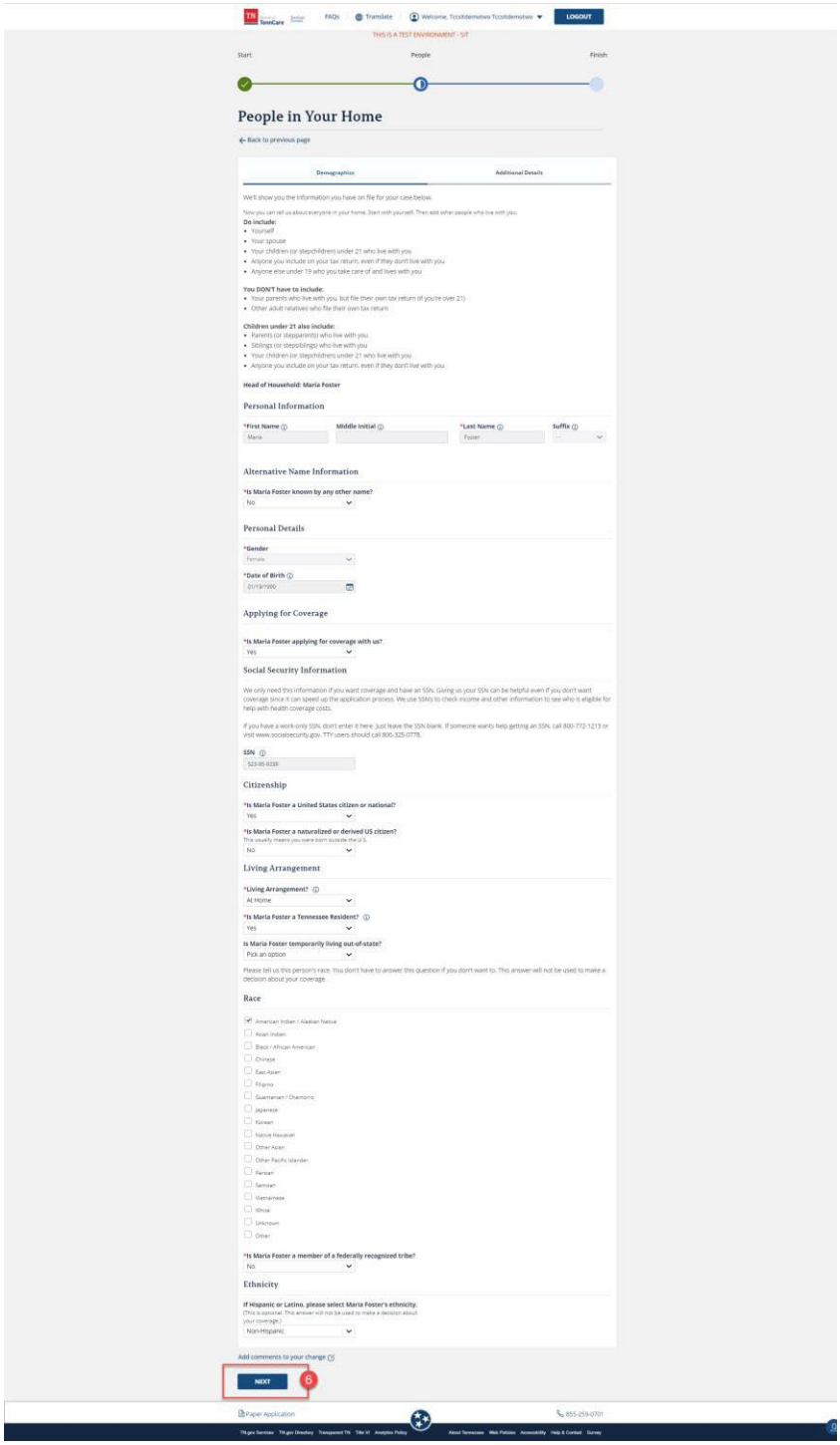
Step 4: As you click on the tile, which will be highlighted in white, the **Next** button will be enabled. Clickon **Next** to navigate to the module.

Step 5: Navigate to **Summary of People In Your Home**, to review information on the case and makechanges to existing information or add any new information.

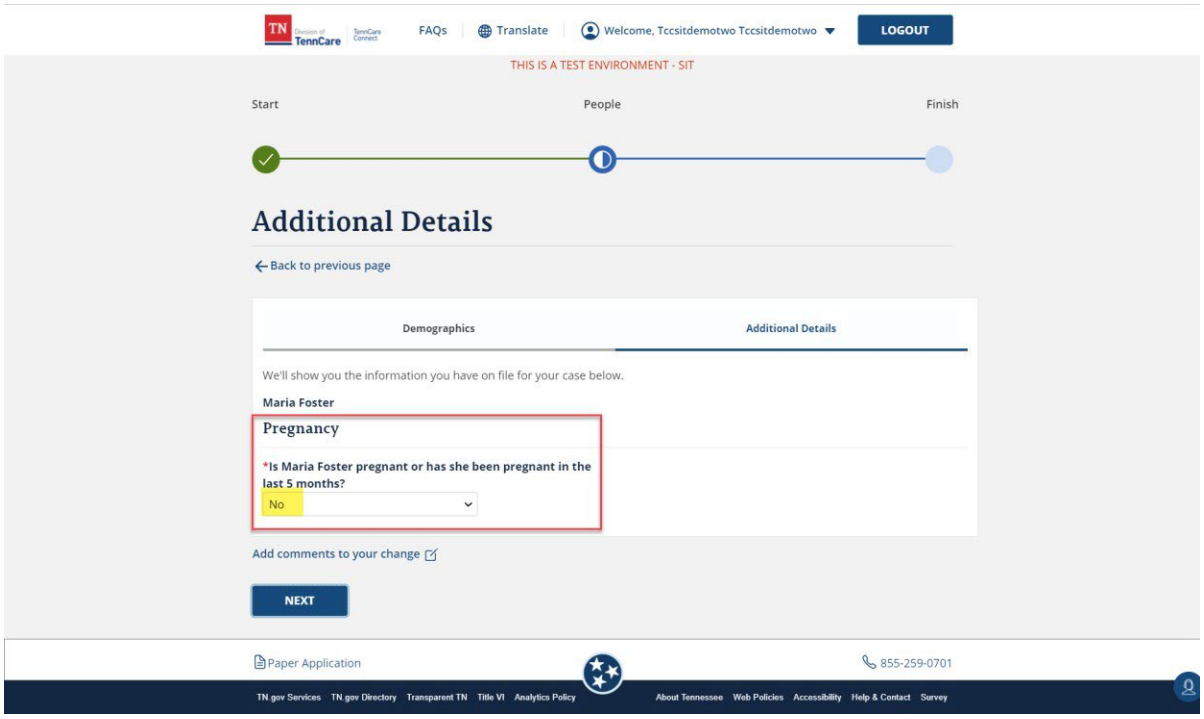
To add pregnancy for Maria Foster, use the **Edit** button to navigate to the corresponding details screen



Step 6: **Edit** button will take you to the first screen in the **People In Your Home** module i.e. **Demographics**. You can see the screen is pre-filled with information already present on the case and cango ahead and click **Next** to navigate to the next sub-screen called **Additional Details**.

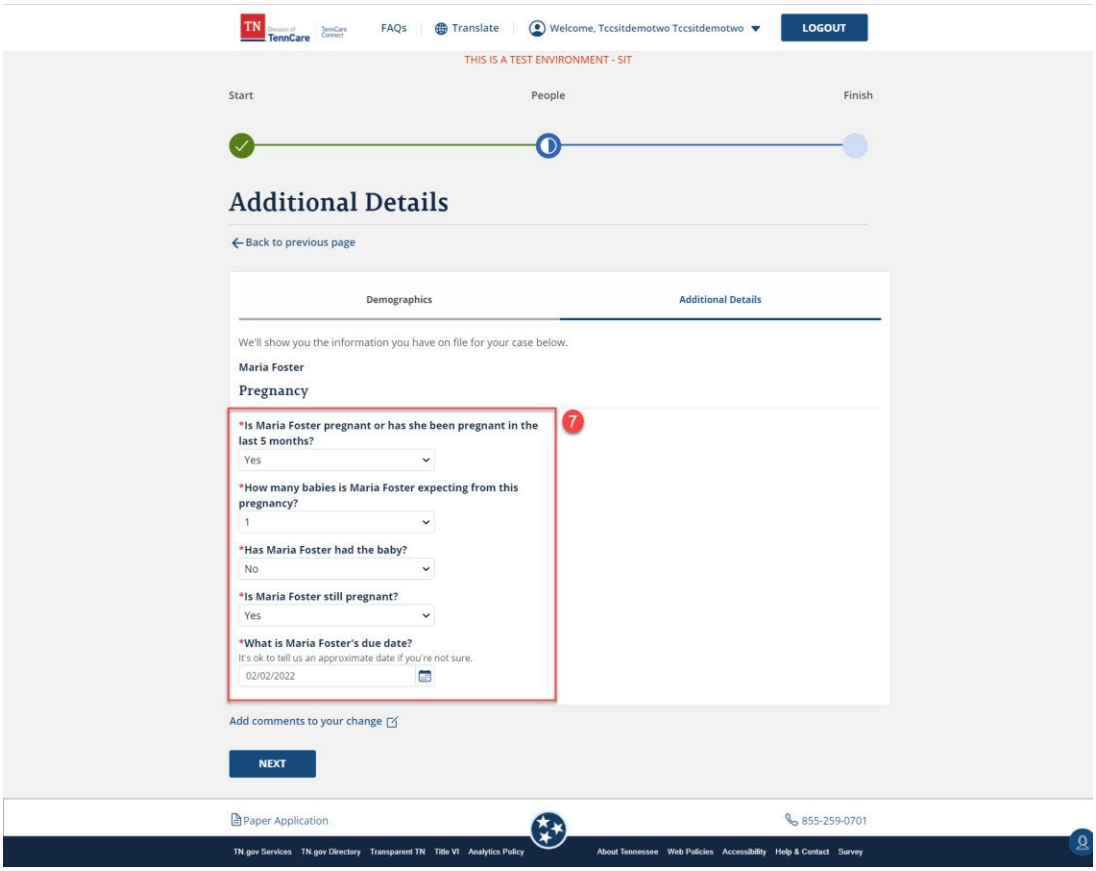


Step 7: On the **Additional Details** screen, you will be able to find a section on Pregnancy. Here, since Maria had no previously reported pregnancies, the question “Is Maria Foster pregnant or has she beenpregnant in the last 5 months?” is pre-filled as ‘No’



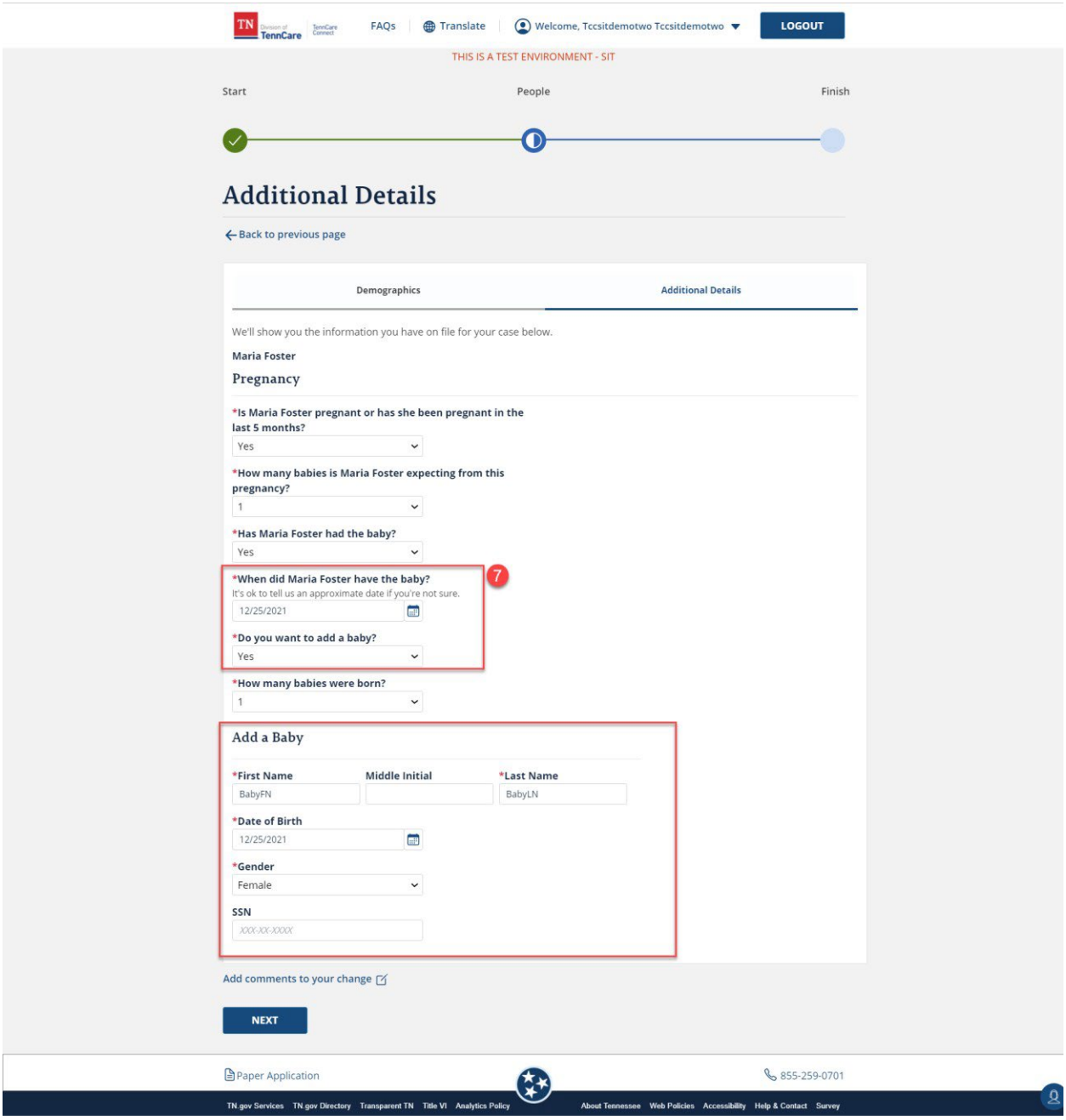
To add pregnancy details for Maria, the question should be marked as **Yes,** to then be presented withmore conditional questions for details.

Step 7(a): To indicate that Maria is still pregnant and is reporting her due date. Click **Next** to be redirected to the **Summary of People In Your Home** screen

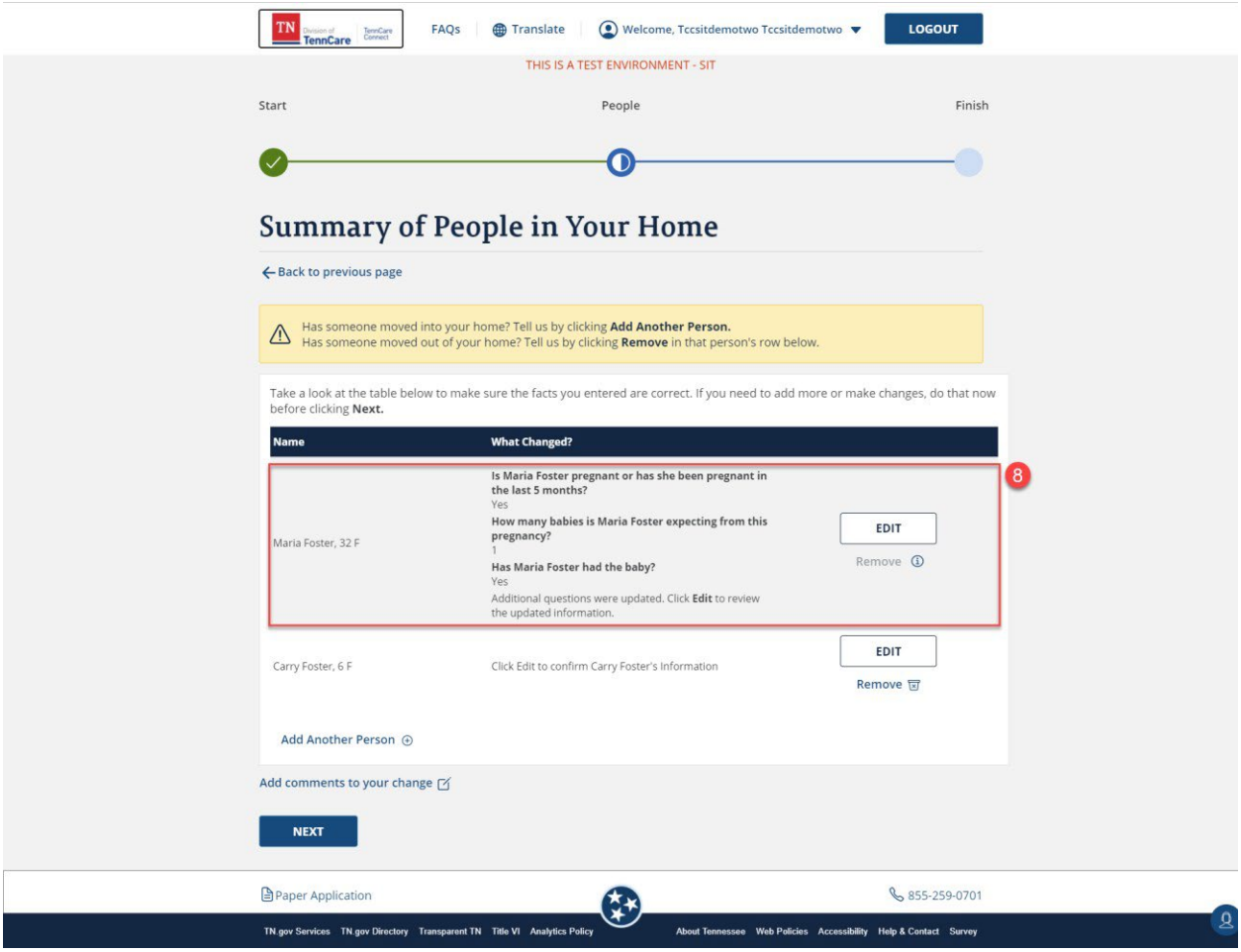


OR

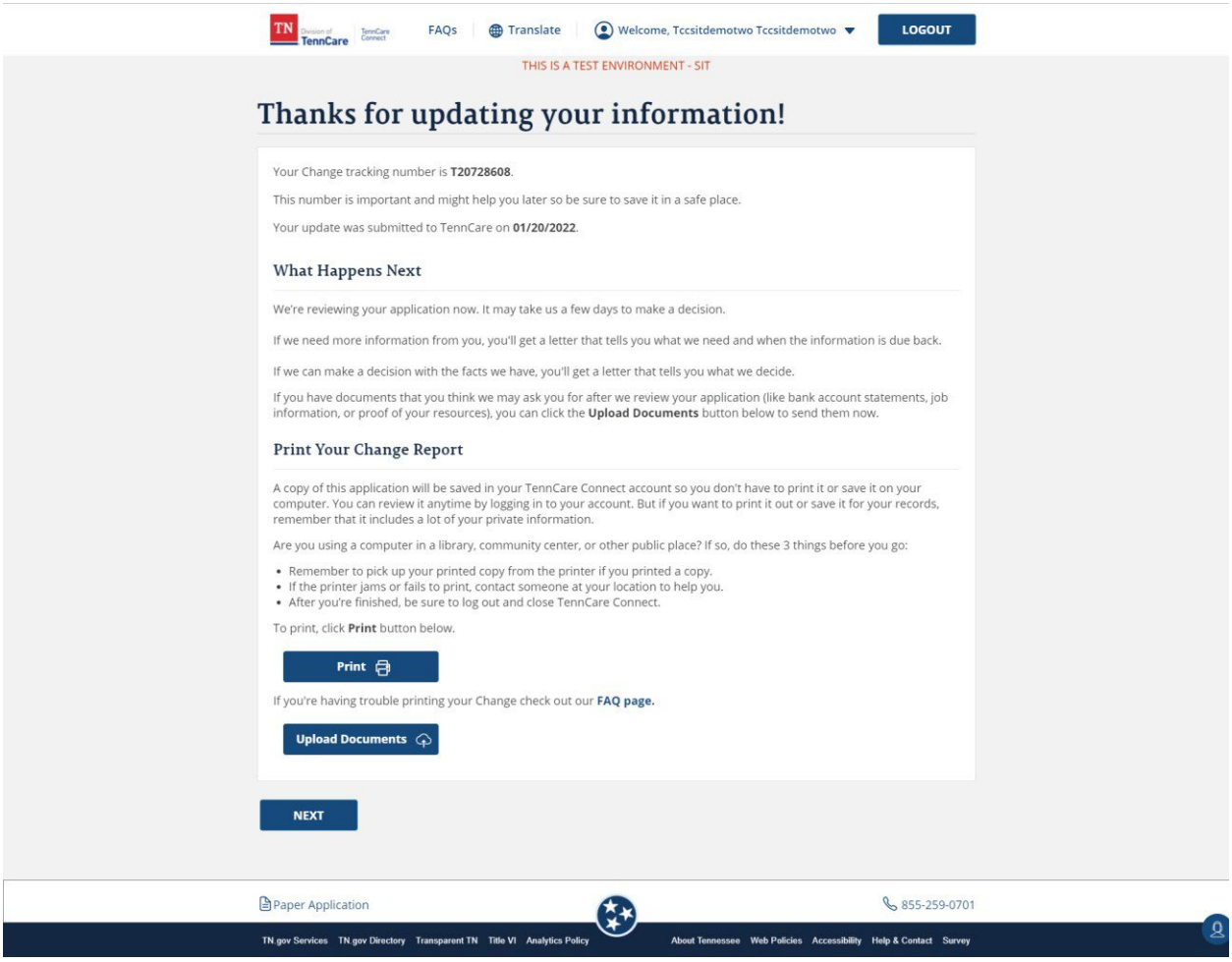
Step 7(b): To indicate that the pregnancy has ended and to add details of the newborn. Click **Next** to beredirected to **Summary of People In Your Home** screen



Step 8: Navigate to **Summary of People In Your Home** to review the newly added pregnancy information for Maria Foster. In this scenario, the **What Changed?** column is reflecting information asentered in **Step 7(b)** as an example.



Step 9: Click **Next** to proceed in the report my changes flow and towards the **Finish** module to submitthe change.



COMPREHENSIVE MEDICAL CONSULTATION FORM

RELEASE OF RECORDS CONSENT

I,_____, hereby consent to the release of my medical records or any information
Patient Name

regarding my health status to _____
Dental Provider Office

_____ _____
Patient Signature Date

DENTAL CONDITION

During the dental treatment this patient is likely to undergo, we normally expect:

BLEEDING: ☐**minimal** ☐**moderate** ☐**substantial**

STRESS: ☐**minimal** ☐**moderate** ☐**substantial**

This patient has presented to our clinic for dental treatment. The following is standard protocol for our treatment of pregnant dental patients:
Necessary radiographs will be taken with lead shielding of the abdomen and the thyroid area.
Treatment may include any of the following: (Please designate with a check mark)

☐ Dental prophylaxis
☐ Scaling and/or root planning
☐ Root canal therapy

2

☐ Fillings
☐ Extractions
☐ Crowns
☐ Topical Fluoride /Topical Fluoride Varnish 5% NaF

3

- If local anesthetic is used, 2% Lidocaine with epinephrine 1:100,000 is used most often
- For non-narcotic pain management, OTC Acetaminophen will be recommended
- If antibiotic is needed, either Amoxicillin or Clindamycin will be prescribed
- *According to the National Maternal and Child Oral Health Consensus Statement "oral health care, including the use of x-rays, pain medication and local anesthesia is safe throughout pregnancy", 2012; http://www.mchoralhealth.org*

_____ _____ _____
Signature Dental Provider Date Email Address

_____ _____ _____
Dental Provider Address Telephone Number

MEDICAL CLEARANCE

- This patient's reported medical condition makes it necessary for us to obtain written information and patient management directives from you.

We must receive your *written* response before dental treatment can begin.

☐ Hypertension

4 At the dental exam on _____this patient's blood pressure was _____. We will not provide any dental treatment if the BP is above 180/105; will perform examination services only when the BP is between 165/95 < 180/105; and will provide most dental care services if the BP is below 165/95. Please evaluate this patient for appropriate medical intervention. We will follow our treatment guidelines unless we receive a written release from you indicating it is safe to treat this patient.

☐ Cardiovascular Disease:

5 ☐Angina: Please indicate the frequency of angina episodes and whether or not this condition is stable. Also comment on the ability of this patient to undergo dental procedures with the indicated amount of stress.

6 ☐MI: Please indicate the date and severity of the myocardial infarct and comment on the ability of this patient to undergo the dental procedures with the indicated amount of stress. We generally wait 6 months post-MI before providing elective dental care services, unless you approve a shorter waiting period.

7 ☐Cerebral Vascular Accident, ☐ TIA's. Please indicate the location of the cerebral event and the extent of functional impairment. Also comment on his/her ability to undergo the dental procedures with the indicated amount of stress.

8 ☐Cardiac Arrhythmia: Please indicate the type of arrhythmia and adequacy of control. We generally administer 2% lidocaine with 1:100,000 epinephrine for effective anesthesia, and will use no more than 2 cartridges which is equivalent to 0.036 mg epinephrine. Does this patient's health status preclude the use of this anesthetic?

9

☐ Antibiotic Prophylaxis

10 The documented increases in antibiotic-resistant microorganisms and allergic reactions in persons taking antibiotics necessitate the conservative use of antibiotics. The goal is to prevent the unnecessary administration of antibiotics prior to dental treatment while providing antibiotic prophylaxis in those patients who are most at risk. Enclosed is a reference that lists cardiac and other medical conditions as well as various dental procedures for which antibiotic prophylaxis is and is not recommended. AHA and AAOS (American Academy of Orthopedic Surgeons) approved antibiotic regimens are included as well as other management recommendations. Please reference this information as you respond to the following questions.

11

12 ☐Low to Moderate Risk Cardiac Condition: This patient reports a history of the following cardiac condition for which the American Heart Association no longer recommends antibiotic prophylaxis: ____This patient states that you recommend continued antibiotic prophylaxis prior to dental treatment. If this is the case, we request that you coordinate prescribing the antibiotics through your office. We have attached a summary of the *2007 AHA Guidelines for Prevention of Infective Endocarditis* for your review.

13

14 ☐Other Systemic Condition(s): This patient reports a history of_____. Please verify and/or clarify this condition and indicate whether or not antibiotic prophylaxis is needed prior to dental treatment associated with significant bleeding or bacteremia. If yes, we will prescribe antibiotic prophylaxis according to the *2007 AHA Guidelines*. (See attached) If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.

15

16 ☐Artificial Joint: This patient reports a history of artificial joint placement more than two years ago and no other risks for hematogenous prosthetic joint infection as defined by the American Academy/Association of Orthopedic Surgeons. The patient states that continued antibiotic prophylaxis has been recommended that appears to be inconsistent with the current (1997) *AAOS Guidelines*. Please advise if there are special considerations that might affect our decision on whether or not to prescribe prophylactic antibiotics. If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.

17

☐ Respiratory Disease

18 ☐Asthma To prevent an acute asthmatic attack during the provision of dental treatment, we request your comments regarding the severity and frequency of this patient's asthmatic attacks and any medications to avoid and/or dental management considerations to adopt for this patient.

19 ☐1°Tuberculosis: Please indicate if this patient has active sputum-positive tuberculosis (Primary Progressive TB). If yes, we will be unable to provide dental services until a physician's written notification is received indicating that the TB has been successfully treated and the patient is no longer infectious.

20 ☐Chronic Obstructive Pulmonary Disease: Please indicate the severity of the COPD and his/her risk for respiratory depression during dental treatment. Also comment on whether or not this patient can withstand dental treatment at the stress level indicated.

21

☐ Diabetes

22 This patient reports a history of ☐ IDDM, ☐NIDDM which ☐ may compromise, ☐has compromised his/her oral health and increase(d) the susceptibility to periodontal disease, oral infections, and/or delayed wound healing. To optimize our management of this patient, please comment on the medications prescribed, how well the diabetes is controlled, recent blood glucose levels and HbA1c, and renal status. If he/she is poorly controlled and susceptible to infection, antibiotic prophylaxis prior to invasive dental treatment may be indicated—please advise.

23

☐ Renal Disease

24 ☐End-Stage Renal Disease: This patient's history of ESRD raises concerns regarding appropriate dental management. Please indicate the presence or absence and the severity of the following conditions associated with ESRD: 1) Hematologic disorders, the potential to bleed excessively, and recent BP, PT, INR, PTT values; 2) Hypertension; 3) Anemia; 4) Nephrotoxic drugs to avoid; and 5) the patient's susceptibility to infection.

25 ☐Hemodialysis: Since hemodialysis increases the patient's exposure risk to hepatitis B, C, and HIV, please indicate if he/she is in an active or carrier state for hepatitis, or infected with HIV. The literature suggests that hemodialysis patients are at low risk of developing infective endarteritis or endocarditis secondary to dental treatment-induced oral bacteremia (assuming no other risk factors exist). Do you recommend antibiotic prophylaxis prior to dental treatment where significant bleeding is anticipated? If yes, we will premedicate as per the 2007 AHA Guidelines.

☐ Liver Disease

26 This patient describes a history of ☐ heavy alcohol consumption, ☐some form of liver damage/disease: _____. Is there evidence of cirrhosis and other related problems such as deficient coagulation factors (II, VII, IX, X); thrombocytopenia, anemia, and leukocytosis? What hepatotoxic drugs should be avoided? Is the patient susceptible to excessive bleeding associated with invasive dental care? Can he/she receive care at this time?

27

☐ Psychiatric Problems:

28 This patient describes a history of ☐ Depression ☐ Bipolar Disorder, ☐Schizophrenia, or ☐ Other Psychiatric Disorder: How severe is this condition and how well is the patient's psychiatric problem managed? Since most antipsychotic drugs cause dry mouth and are associated with other oral health problems, antipsychotics with minimal anticholinergic or parafunctional side effects are desirable.

☐ Allergies/Concerns Regarding Medications:

29 ☐Allergy: This patient reports an allergy or side effect to: _____ and describes the following symptom (s): _____. Please verify the presence or absence of this problem, and provide any patient management recommendations. If this is a drug allergy, please suggest an alternative medication appropriate for this patient.

30 ☐Local Anesthetic Use: The School of Dentistry routinely uses 2% lidocaine with 1:100,000 epinephrine as local anesthetic. Does this patient's health status preclude the use of this anesthetic? Please advise.

☐ Seizures

DentaQuest

31 ☐Please indicate the type, frequency, and precipitating factors of this patient's seizures as well as the current degree of seizure control. Also comment on the ability of this patient to undergo dental procedures with the indicated amount of stress.

☐ Other Medical Problems:

32 ☐Pregnancy. This patient indicates that she is in her ☐First, ☐Second, ☐Third trimester of pregnancy. She now has ☐urgent ☐non-urgent dental needs. Elective, non-urgent dental treatment is reserved for the 2nd trimester or after pregnancy. We generally administer 2% lidocaine with 1:100,000 epinephrine for effective anesthesia and take limited radiographs using appropriate lead apron shielding. If you have any concerns, please advise. What oral analgesics and antibiotics would you recommend be prescribed to this patient if necessary?

33

34 ☐Immunocompromised: ☐ Corticosteroids ☐ Chemotherapy ☐ Autoimmune disease ☐ HIV ☐ Organ Transplant ☐ Other

35 Because _____ increases this patient's susceptibility to infections, do you recommend antibiotic prophylaxis prior to invasive dental treatment likely to cause significant bleeding/oral bacteremia? What other management recommendations do you have? ☐Radiation: Because of concerns for the development of osteoradionecrosis and its complications associated with future oral surgical procedures, please indicate the location, total radiation dosage, and any evidence of major salivary gland damage. Any patient management suggestions to avoid osteoradionecrosis are welcome.

36

37 ☐Radiation: Because of concerns for the development of osteoradionecrosis and its complications associated with future oral surgical procedures, please indicate the location, total radiation dosage, and any evidence of major salivary gland damage. Any patient management suggestions to avoid osteoradionecrosis are welcome.

38

39 ☐Corticosteroid Use: This patient reports a history of ☐ long-term, ☐short-term systemic corticosteriod use. Other than major oral surgical procedures (bony impacted extractions, bone resections, oral cancer surgery, etc.), few dental procedures warrant supplemental steroid use before, during, or after the operative period. In the event of invasive oral surgical procedures, steroid supplementation may be indicated to prevent an adrenal crisis in individuals with adrenal insufficiency. Do you recommend this patient increase his/her corticosteroid dosage before such dental appointments? If so, by what amount? Please coordinate any changes in corticosteroid dosage through your office.

40

41 ☐Hypothyroidism/Hyperthyroidism: Is this patient's thyroid function within normal limits?

42

43 ☐Questionable Medical History: When reviewing this patient's medical history, we identified one or more uncertainties/inconsistencies. _____ Please provide information regarding this patient's medical history and comment on his/her ability to withstand the indicated stress and bleeding.

44

45 ☐ Drug Addition: Please advise on the stint of usage/treatment _____. The School of Dentistry routinely uses 2% lidocaine with 1:100,000 epinephrine as local anesthetic. Does this patient's health status preclude the use of this anesthetic? What other management recommendations do you have? Please advise.

☐ Other: Patient states current medical history of : _____. Please give dental precaution as it relates to extraction using 2% lidocaine with 1:100,000 epinephrine.

46

☐ Anticoagulant/Antithrombotic/Antiplatelet Medications:

47 This patient reports a history of anticoagulant therapy. To appropriately manage this patient, avoid lengthy discontinuation of anticoagulant, and minimize an embolic event, we need laboratory results of the patient's three most recent INR or PT values, including tests dates. 48 ☐This patient requires routine oral surgical procedure (simple extractions, gingival curettage, root planning, etc.) where minimal-to-moderate bleeding is expected. If the INR is currently below 3.0, no manipulation of the anticoagulant is indicated. (Generally, INR values below 3.0 do not require manipulation of anticoagulant prior to surgical procedures where minimal bleeding is expected and local hemostatic measures are effective.) 49
50 ☐This patient requires more complex oral surgical procedures (full mouth/full arch extractions, minor to more extensive periosteal flap surgery, extraction of impacted teeth, implant placements, etc.) where more substantial bleeding is expected. In this case an INR between 1.5-2.0 is preferred. Based on the current INR value, a reduction in anticoagulant dosage or a 2-3 day discontinuation may be indicated to achieve a 1.5-2.0 INR level prior to oral surgery. To minimize the risk of an embolic event, please avoid a 4 to 5+ day discontinuation of anticoagulant. Please advise. 51
52 ☐Aspirin/Plavix/NSAID: This patient reports a history of daily aspirin/Plavix or NSAID use and will undergo oral surgical procedures that are likely to cause moderate to substantial bleeding. Please indicate the three most recent BT values and test dates. Depending on the BT values, it may be prudent to have the patient reduce or discontinue this medication 7-10 days prior to the oral surgical procedures. Please advise.

Please circle and sign below for medical clearance or indicate further guidance for dental treatment:

I agree with the above treatment: _____ _____
Physician Signature Date

Please indicate any precautions or contraindications to treatment: _____
_____

I disagree with the above mentioned treatment protocol and would like to provide additional guidance:

_____

_____

_____ _____
Physician Signature Date

Please return to:

_____ _____ _____
Dental Provider Office Telephone Number Fax Number

_____ _____
Address City/State/Zip Code

DentaQuest

TennCare Adult Dental Program

DENTAL CARE REFERRAL FORM

FOR PREGNANT WOMEN TO RECEIVE ORAL HEALTH CARE

Referred to: _____ _____
Dental Provider Office Date

Patient Name: _____ DOB: _____ Date: _____

Expected Due Date: _____ Current Week of Gestation: _____ Allergies: _____

☐ Pregnancy Precautions /Pertinent Medical History: _____
_____

This patient is cleared to receive routine dental evaluation and care, including but not limited to:

- Oral health examination
- Dental prophylaxis
- Scaling and root planning
- Extraction
- Dental radiograph with abdominal and neck lead shield
- Local Anesthetic with epinephrine
- Root canal
- Restorations (amalgam or composite) fillings

This patient is cleared to receive the following medications: (Check all that apply)

Treatment may include any of the following:

☐ Acetaminophen with codeine for pain control
☐ Penicillin
☐ Clindamycin
☐ Erythromycin (Not estolate form)
☐ Alternative pain control medication: (Specify)_____
☐ Amoxicillin
☐ Cephalosporins
53

_____ _____ _____
Pre-natal Healthcare Provider Phone Email Address

_____ _____
Signature Prenatal Healthcare Provider Date

DENTAL PROVIDER REPORT

Diagnosis:_____
_____

Treatment Plan: _____ _____

_____

_____ _____ _____
Name Date Phone

Signature of Dentist: _____ Email: _____

EMERGENCY MEDICAL CLEARANCE FORM

RELEASE OF RECORDS CONSENT

I,_____, hereby consent to the release of my medical records or any information
Patient Name

regarding my health status to _____
Dental Provider Office

_____ _____
Patient Signature Date

MEDICAL CLEARANCE REQUEST

Patient Name: _____ DOB: _____ Date: _____

Expected Due Date: _____ Week of Gestation: _____ Allergies: _____

Pregnancy/Medical History: _____

This patient has presented to our clinic for dental treatment. The following is standard protocol for our treatment of pregnant dental patients:

Necessary radiographs will be taken with lead shielding of the abdomen and the thyroid area

- Treatment may include any of the following:
  - Dental prophylaxis
  - Scaling and/or root planning
  - Root canal therapy
  - Fillings
  - Extractions
  - Crowns
  - Topical Fluoride /Topical Fluoride Varnish 5% NaF
- If local anesthetic is used, 2% Lidocaine with epinephrine 1:100,000 is used most often
- For non-narcotic pain management, OTC Acetaminophen will be recommended
- If antibiotic is needed, either Amoxicillin or Clindamycin will be prescribed
- *According to the National Maternal and Child Oral Health Consensus Statement "oral health care, including the use of x-rays, pain medication and local anesthesia is safe throughout pregnancy", 2012; http://www.mchoralhealth.org*

_____ _____
Signature Dental Provider Email Address

MEDICAL CLEARANCE

Please sign below for medical clearance or indicate further guidance for dental treatment:

I agree with above protocol: _____ _____
Physician Signature Date

I disagree with the above mentioned protocol and would like to provide additional guidance:

_____

_____

_____ _____
Physician Signature Date

Please return to:

_____ _____ _____
Dental Provider Office Telephone Number Fax Number

_____ _____
Address City/State/Zip code

DentaQuest

TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form

This form is required to be submitted with documentation as outlined in Section 15.00, Criteria for Provision of Dental Treatment in an Inpatient/Outpatient Hospital ("Hospital") Facility or in an Ambulatory Surgical Center (ASC)

Patient Name _____

Patient ID _____

Patient Address _____

_____

Date _____

A. I certify that I have examined this patient
☐ Yes ☐ No Date of Exam _____

B. There is pathology or injury requiring extensive dental treatment (restorative or surgical)
☐ Yes ☐ No

C. I certify that I have attempted to treat this patient in my office
☐ Yes ☐ No Date _____

D. If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)
☐ Yes ☐ No

If no, why was a referral not made?

_____

_____

E. I have attempted to manage the member with Silver Diamine Fluoride in the office (general and pediatric dentists)
☐ Yes ☐ No

F. I have offered Silver Diamine Fluoride treatment to the member in the office as an alternative to treatment under general anesthesia in a medical facility (general and pediatric dentists)
☐ Yes ☐ No

G. If answer to "E" or "F" is no, please explain why SDF has not been used (general and pediatric dentists

_____

_____

_____

H. Were radiographs taken to determine diagnosis?

☐ Yes ☐ No

I. I have submitted all the documentation required for prior authorization as described in the TennCare Office Reference Manual

☐ Yes ☐ No

J. If answer to "H" or "I" is no, please explain why the documentation is not being submitted:

_____

_____

DentaQuest reserves the right to request a second opinion for any inpatient/ outpatient hospital or ambulatory surgery center request.

I Certify That the Above Information Is Correct

Name of Provider _____

Provider Signature _____

Date _____

Submit to:

DentaQuest – TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
FAX: 262.834.3452

TennCare Provider Post Service Appeal Form

Provider Name:	
Provider NPI Number:	
Provider Phone Number	
Facility Contact Person:	

Type:	CGA Provider Appeal
Claim Number for Appeal:	
Claim Lines for Appeal:	
Description of Issue for Appeal:	
Attachments Yes/No:	
Member/Subscriber Name:	
Member/Subscriber Number/ID:	

Please note:
*Please do not send an ADA claim form with your appeal.
**An Appeal is a written request for a review of an adverse benefit determination taken by DentaQuest.
No other types of requests should be sent to the CGA Appeals Department.

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a
TennCare Medical Appeal.

Need help filing a medical appeal?
☐ Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

---

1. Who is the person that wants to appeal?

Full name_____ Date of birth____/____/_____

Social Security Number____ - ____ - _____ Or number on their TennCare card_____

Current mailing address_____

City_____ State_____ Zip Code_____

The name of the person we should call if we have questions about this appeal:

A daytime phone number for that person (____) _____ - _____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name._____

Are you a:_____Parent, relative, or friend_____Advocate or attorney_____Doctor or health care provider*

(*You need your patient's written permission to file this appeal. See the third page.)

3. What is the appeal for? (Place an **X** beside the right answer below.)

_____Want to **change health plans.** (Fill out **Part A** on page 2.)

_____**Need care or medicine.** (Fill out **Part B** on page 2.)

_____Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records. An emergency means that waiting 90 days for a "yes" or "no" decision **could put your life or physical or mental health in real danger**.

Do you still think you have an emergency? If so, you can ask TennCare for an **expedited** appeal by calling 1-800-878-3192. Your **doctor** can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing.** Write **your name, your date of birth, your doctor's name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see **There are 3 ways to file an appeal** for our address and fax number). What if you don't send us your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out, sign and send back to us.

After you give your OK in writing, your doctor can help by completing a "Provider's Expedited Appeal Certificate". Your doctor can get the page from TennCare's website. **Go to tn.gov/tenncare.** Click "Providers," and then click "Miscellaneous Provider Forms." Your doctor should fax this certificate and your medical records to TennCare. TennCare **and** your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week. Remember, it could take longer if your health plan needs more time to get your medical records.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want_____

Part B. Need care or medicine. What kind - be specific_____

What's the problem? _____Can't get the care or medicine at all.
_____Can't get as much of the care or medicine as I need.
_____The care or medicine is being cut or stopped.
_____Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine?_____Yes_____No If yes, doctor's name_____
Have you asked your health plan for this care or medicine?_____Yes_____No If yes, when?_____
What did they say?_____
Did you get a letter about this problem?_____Yes_____No If yes, the date of the letter_____
Who was the letter from?_____
Are you getting this care or medicine from TennCare now? _____Yes____No
Do you want to see if you can keep getting it during your appeal? _____Yes____No
Does your doctor say you still need it?_____Yes_____No If yes, doctor's name_____
If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____Name of doctor, drug store, or other place that gave you the care or medicine_____Their phone number (____) _____ - _____
Their address_____
Did you **pay for the care or medicine and want to be paid back?**_____Yes_____No
If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.
If you didn't pay, **are you getting a bill?**_____Yes_____No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know).

How to file your medical appeal

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:

TennCare Member Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.
If you think you've been treated unfairly, call TennCare Connect for free at **1-855-259-0701.**

STATE OF TENNESSEE
DIVISION OF TENNCARE
TennCare Member Medical Appeals
P.O. Box 000593 Nashville,
Tennessee 37202-0593

Appeal Authorization Form

Patient's Printed Name_____

Patient's Date of Birth_____

Doctor's Printed Name_____

Yes, I would like to request a Fair Hearing from TennCare for.

_____.

(Drug, item, or service)

☐ I give my doctor permission to file a fair hearing request on my behalf.

☐ I want to keep getting the services I've been getting until my appeal is over. I understand that my health plan will look at my case and decide if I can keep getting this care during my appeal.

_____ _____

Signature of Patient **Date**

_____

Address

_____

Phone Number

Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

Federal and State laws do not allow the TennCare Program to treat you differently because of your race, color, birthplace, disability, age, sex, religion, or any other group protected by law. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name: _____

Address: _____

_____ Zip _____

Telephone: (____)_____ Date of Birth: _____

Email Address: _____

Name of MCO/Health Plan:

_____

2.* Are you reporting this complaint for someone else? Yes: _____ No: _____

If Yes, who do you think was treated differently because of their race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?

Name: _____

Address: _____

_____ Zip _____

Telephone: Home: (____) _____ Date of Birth: _____

How are you connected to this person (wife, brother, friend)?

_____

Name of this person's MCO/Health Plan:

_____

3.* Which part of the TennCare Program do you think treated you in a different way:

Medical Services ☐ Dental Services ☐ Pharmacy Services ☐ Behavioral Health ☐

Long-Term Services & Supports ☐ Eligibility Services ☐ Appeals ☐

TC 0136 (REV. 2-21)

RDA – 11078

4.* How do you think you were you treated in a different way? Was it your:
Race ☐ Birthplace ☐ Color ☐ Sex ☐ Age ☐ Disability ☐ Religion ☐ Other_____

5. What is the best time to talk to you about this complaint? _____

6.* When did this happen to you? Do you know the date?
Date it started: _____ Date of the last time it happened: _____

7. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

_____
_____
_____

8.* What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

_____
_____
_____

9. Did anyone see you being treated differently? If so, please tell us their:
Name Address Telephone

_____
_____
_____

10. Do you have more information you want to tell us about?

_____
_____

11.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

_____
(Sign your name here if you are the person this complaint is for) (Date)

_____
(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are not the person's Authorized Representative? Please sign your name below. The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

_____

(Sign here if you reporting this for someone else) (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:

_____

(Sign here if you are a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail or email the completed, signed Complaint and the signed Agreement to Release Information pages to us at:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

You can also call us if you need help with this information.

Division of TennCare

TennCare Agreement to Release Information

To investigate your complaint, TennCare may need to tell other persons or organizations important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint TennCare may need to share my name, date of birth, claims information, health information, or other information about me to other persons or organizations. And TennCare may need to gather this information about you from persons or organizations. For example, if I report that my doctor treated me in a different way because of my color, TennCare may need to talk to my doctor and gather my medical records.

- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. If you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. We may have to close your case. Before we close your case because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare sharing my name or other information about me to other persons or organizations important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: _____ Date: _____

Name (Please print): _____

Address: _____

Telephone: _____

Need help? Want to report a complaint? Please contact or mail a completed, signed Complaint and a signed Agreement to Release Information form:

TennCare OCRC
310 Great Circle Road, 3W
Nashville, TN 37243

Phone: 1-615-507-6474 or for free at 1-855-857-1673 (TRS 711)
Email: HCFA.fairtreatment@tn.gov

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: **کوردی**

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 855-259-0701 (1-800-848-0298) TTY بکە.

Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).

German:	**Deutsch** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).
Tagalog:	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).
Hindi:	**हिंदी** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।
Serbo-Croatian:	**Srpsko-hrvatski** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).
Russian:	**Русский** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).
Nepali:	**नेपाली** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।
Persian:	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.

- **Do you need help talking with us or reading what we send you?**
- **Do you have a disability and need help getting care or taking part in one of our programs or services?**
- **Or do you have more questions about your health care?**

Call us for free at 1-855-259-0701. We can connect you with the free help or service you need.
(For TTY call: 1-800-848-0298)

Division of TennCare

TENNCARE QUEJA DE DISCRIMINACIÓN

Las leyes federales y estatales no permiten que el Programa TennCare lo trate de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley**. ¿Piensa que ha sido tratado de manera diferente por estas razones? Use estas hojas para presentar una queja a TennCare.

Es obligatorio proporcionar la información marcada con un asterisco (*). Si necesita más espacio para decirnos lo que pasó, use otras hojas de papel y envíelas con su queja.

1.* Escriba su nombre y dirección.

Nombre: _____

Dirección: _____

_____ Código postal _____

Teléfono: Hogar: (____)_____ Trabajo o Celular: (____)_____

Dirección de correo electrónico: _____

Nombre del MCO/plan de seguro médico:

_____

2.*¿Está usted presentando esta queja en nombre de otra persona?

Sí: ☐ No: ☐

Si respondió Sí, ¿quién piensa usted que fue tratado de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley?**

Nombre: _____

Dirección: _____

_____ Código postal _____

Teléfono: Hogar: (_____)_____Trabajo o Celular: (_____)_____

¿Qué relación tiene usted con esta persona (cónyuge, hermano, amigo)?

_____

Nombre del MCO/plan de seguro médico de esa persona:

_____

3.* ¿Cuál parte del Programa TennCare cree que lo trató de una manera diferente?

Servicios médicos☐ Servicios dentales☐ Servicios de farmacia☐ Salud conductual☐

Servicios y apoyos de largo plazo☐ Servicios de elegibilidad☐ Apelaciones☐

4.* ¿Por qué cree que lo trataron de una manera diferente? Fue a causa de su

Raza☐ Lugar de nacimiento☐ Color de la piel☐ Sexo☐ Edad☐

Discapacidad☐ Religión☐ Otra cosa_____

5. ¿Cuál es la mejor hora para llamarlo acerca de esta queja?

_____

6.* ¿Cuándo sucedió esto? ¿Sabe la fecha?

Fecha en que comenzó: _____ Última fecha en que sucedió: _____

7. Las quejas deben reportarse no más de 6 meses de la fecha en que piensa que fue tratado de una manera diferente. Si tiene una causa justificada (como enfermedad o fallecimiento en la familia), puede reportar su queja más de 6 meses después.

_____

_____

8.* ¿Qué sucedió? ¿Cómo y por qué piensa que pasó? ¿Quién lo hizo? ¿Piensa que alguna otra persona también fue tratada de una manera diferente? Si necesita más lugar, puede escribir en otra(s) hoja(s) y enviarlas con estas hojas.

_____

_____

_____

9. ¿Alguien vio cómo lo trataban de una manera diferente? Si es así, por favor, proporcione la siguiente información sobre esa persona:

Nombre **Dirección** **Teléfono**

_____

_____

_____

10. ¿Tiene usted más información que nos desee dar?

_____

_____

_____

11.*No podemos aceptar ninguna queja que no esté firmada. Por favor, escriba su nombre y la fecha en la línea de abajo. ¿Es usted el Representante Autorizado de la persona que piensa que fue tratada de manera diferente? Firme abajo. Como el Representante Autorizado, usted debe tener un comprobante de que puede actuar en nombre de esta persona. Si el paciente es menor de 18 años de edad, uno de los padres o tutor debe firmar en su nombre. **Declaración:** *Declaro que la información presentada en esta queja es verídica y correcta y doy mi autorización para que TennCare investigue mi queja.*

_____

(**Firme aquí si usted es la persona de quien trata esta queja**) (Fecha)

_____

(Firme aquí si usted es el Representante Autorizado) (Fecha)

¿Está usted reportando esta queja en nombre de otra persona pero usted **no** es el Representante Autorizado de la persona? Firme abajo. **La persona para quien usted está reportando esta queja debe firmar arriba o debe decirle a su plan de seguro médico o a TennCare que está bien que él/ella firme en su lugar. Declaración:** *Afirmo que la información contenida en esta queja es verdadera y correcta y doy mi permiso para que TennCare se comunique conmigo acerca de esta queja.*

_____

(Firme aquí si está reportando en nombre de otra persona) (Fecha)

¿Es usted ayudante de TennCare o del MCO/plan de seguro médico y está ayudando al miembro de buena fe a presentar la queja? Si es así, por favor firme abajo:

_____

(Firme aquí si usted es ayudante de TennCare o del MCO/plan de seguro médico) (Fecha)

Está bien que reporte una queja a su MCO/plan de seguro médico o a TennCare. La información contenida en esta queja se trata de manera privada. Los nombres y otros datos sobre las personas que aparecen en esta queja sólo se divulgan cuando es necesario. Por favor, envíe una hoja de Autorización para Divulgar Información con su queja. Si está presentando esta queja en nombre de otra persona, pídale a la persona que firme la hoja de Autorización para Divulgar Información y envíela por correo con esta queja. Conserve una copia de todo lo que envíe. Envíe las hojas firmadas de la Queja **y la** Autorización para Divulgar Información a:

TennCare OCRC
310 Great Circle Road, 3rd Floor
Nashville, TN 37243
Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TRS gratis, marque el 711
Correo electrónico: HCFA.fairtreatment@tn.gov

También puede llamarnos si necesita ayuda con esta información.

Division of TennCare

Acuerdo de divulgación de información de TennCare

Para investigar su reclamo, es posible que TennCare deba informar a otras personas u organizaciones importantes su nombre u otra información sobre usted.

Para acelerar la investigación de su reclamo, lea, firme y envíe por correo postal una copia de este Acuerdo de divulgación de información junto con él. Guarde una copia para usted.

• Comprendo que durante la investigación de mi reclamo, es posible que TennCare deba compartir mi nombre, fecha de nacimiento, información sobre reclamaciones, información médica u otra información sobre mí con otras personas u organizaciones. Igualmente, es posible que TennCare deba recopilar esta información sobre usted a través de personas u organizaciones. Por ejemplo, si denuncio que mi médico me trató de una manera diferente debido a mi color, es posible que TennCare deba hablar con mi médico y recopilar mis registros médicos.

• Usted no estará obligado a aceptar la divulgación de su nombre u otra información. No siempre será necesario investigar su reclamo. Si no firma la autorización de divulgación, igualmente intentaremos investigar su reclamo. Si no acepta permitirnos usar su nombre u otros datos, la investigación de su reclamo se podrá ver limitada o suspendida. Es posible que tengamos que cerrar su caso. Antes de cerrar su caso por el hecho de que usted no firmó la autorización de divulgación, podremos comunicarnos con usted para averiguar si desea firmar una autorización de divulgación para que la investigación pueda continuar.

Si usted presenta este reclamo en nombre de otra persona, necesitaremos que esa persona firme el Acuerdo de divulgación de información. ¿Está firmando este documento como representante autorizado? Entonces, también deberá proporcionarnos una copia de los documentos que lo designan a usted como el representante autorizado.

Al firmar este Acuerdo de divulgación de información, acepto que he leído y comprendo los derechos que se mencionaron anteriormente. Acepto que TennCare comparta mi nombre u otra información sobre mí con otras personas u organizaciones que sea importante para este reclamo durante la investigación y el resultado del mismo.

Este Acuerdo de divulgación de información tendrá vigencia hasta el resultado final de su reclamo. Usted podrá cancelar su acuerdo en cualquier momento llamando o escribiendo a TennCare sin cancelar su reclamo. Si cancela el acuerdo, no se podrá eliminar por completo la información que ya se haya compartido.

Firma:_____Fecha: _____

Nombre (en letra de imprenta):

_____

Dirección:

_____

Teléfono:

_____

¿Desea realizar un reclamo? Envíe por correo postal un reclamo completado y **firmado** y un formulario del **Acuerdo de divulgación de información firmado** a la siguiente dirección:

OCRC de TennCare
310 Great Circle Road, 3W
Nashville, TN 37243

Teléfono: 1-615-507-6474 o en forma gratuita al 1-855-857-1673 (TRS 711)

Correo electrónico: HCFA.fairtreatment@tn.gov

¿Necesita ayuda gratuita con esta carta?
Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.
Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).
Kurdish: کوردی ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 855-259-0701 (1-800-848-0298) TTY بکە.
Arabic: العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701 (رقم هاتف الصم والبكم:1-800-848-0298).
Chinese: 繁體中文 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: **ພາສາລາວ**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ ວຍເຫ ຼືອດ້ ານພາສາ, ໂດຍບໍ ່ ເສັ ຽຄ່ າ, ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).

German: **Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).

Tagalog: **Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).

Hindi: **हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।

Serbo-Croatian: **Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).

Russian: **Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).

Nepali: **नेपाली**
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.

- ¿Necesita ayuda para hablar con nosotros o para leer lo que le enviamos?
- ¿Tiene alguna discapacidad y necesita ayuda para su cuidado o para tomar parte en uno de nuestros programas o servicios?
- ¿O tiene más preguntas sobre su atención médica?

Llámenos gratis al 1-855-259-0701. Podemos conectarlo con la ayuda o servicio gratuito que necesite.
(Para el sistemaTTY (Para los sordos) llame al: 1-800-848-0298)

Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

لا تسمح القوانين الاتحادية وقوانين الولايات لبرنامج TennCare أن يقوم بالتمييز ضدك بسبب **عرقك أو لونك أو مكان ميلادك، أو عجزك، أو عمرك، أو جنسك، أو دينك، أو أي فئة أخرى يحميها القانون.** هل تعتقد أنك قد تعرضت للتمييز لهذه الأسباب؟ استخدم تلك الصفحات للإبلاغ عن أي شكوى إلى برنامج TennCare.

يتعين عليك الإجابة على المعلومات التي تحمل علامة نجمة (*). وإن احتجت إلى المزيد من المساحة لتخبرنا بما حدث، فاستخدم أوراق أخرى وارسلها مع شكوتك.

1. * اكتب اسمك وعنوانك.

الاسم:_____

العنوان:_____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أو المحمول (_____)_____

البريد الإلكتروني: _____

اسم منظمة الرعاية المدارة \خطة الصحة:

_____

2. * هل تبلغ عن هذه الشكوى من أجل شخص آخر؟ نعم: _____ لا:_____

إن كانت الإجابة نعم، فمن هو الشخص تعرض للتمييز بسبب **العرق، أو اللون، أو مكان الميلاد، أو العجز\الإعاقة، أو العمر، أو الجنس، أو الدين، أي فئة أخرى يحميها القانون؟**

الاسم:_____

العنوان: _____

_____الرمز البريدي _____

الهاتف: المنزل (_____)_____ العمل أم المحمول (_____)_____

ما هي صلتك بذلك الشخص (زوجة، أخ، صديق)؟

اسم منظمة الرعاية المدارة \خطة الصحة الخاصة بذلك الشخص:

_____

3. * أي جزء من برنامج TennCare تعتقد أنه قام بالتمييز ضدك:

الخدمات الطبية ☐ خدمات طب الأسنان ☐ الخدمات الصيدلية ☐ الصحة السلوكية ☐

الدعم والخدمات طويلة المدى ☐ خدمات الأهلية ☐ الالتماسات ☐

4. *كيف تعرضت للتمييز؟ هل كان بسبب

عرقك ☐ مكان ميلادك ☐ لونك ☐ عمرك ☐

عجزك ☐ دينك ☐ سبب آخر _____

5. ما هو أنسب وقت للتحدث إليك بشأن هذه الشكوى؟

_____

6. * متى حدث ذلك لك؟ هل تعلم التاريخ؟

تاريخ بداية الحدث: _____ تاريخ آخر مرة حدث ذلك: _____

7. يتعين عليك الإبلاغ عن الشكوى قبل 6 أشهر من تاريخ اليوم الذي تعرضت فيه للتمييز.

يجوز لك الحصول على أكثر من 6 أشهر للإبلاغ عن الشكوى إذا كانت هناك أسباب قوية لانتظارك كل هذه الفترة (مثل حالة وفاة في عائلتك أو مرض ما).

_____

_____

_____

8. *** ما الذي حدث؟** كيف ولماذا تعتقد أن ذلك حدث؟ من قام بذلك؟ هل تعتقد أن أي هناك شخص آخر تعرض للتمييز؟ يمكنك الكتابة على المزيد من الورق وإرساله مع هذه الصفحات إذا احتجت لمزيد من المساحة.

_____

_____

_____

9. **هل هناك شاهد على ذلك التمييز؟** إن كان الأمر كذلك، يرجى إخبارنا بـ:

الاسم	**العنوان**	**الهاتف**

_____

_____

10. هل لديك مزيد من المعلومات تريد أن تطلعنا عليها؟

_____

_____

11.* لا يمكننا استلام شكوى غير موقعة. يرجى كتابة اسمك والتاريخ على السطر أدناه. هل تعد ممثلاً مخولاً للشخص الذي تظن أنه تعرض للتمييز؟ يرجى توقيع اسمك أدناه. وبصفتك الممثل المخول، فلابد أن يكون لديك دليل على أنه يمكنك التصرف نيابة عن ذلك الشخص. إذا كان المريض أصغر من 18 عام، فيتعين على الوالد و الوصي التوقيع للقاصر. ***بيان:*** *أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج* ***TennCare*** *موافقتي للتحقيق في شكوتي؟*

_____

(وقع اسمك هنا إن كنت أنت الشخص الذي تتعلق به هذه الشكوى) (التاريخ)

_____ (وقع هنا إن كنت الممثل

المخول) (التاريخ)

هل تبلغ عن هذه الشكوى لشخص آخر ولكنك **لست** الممثل المخول للشخص؟ يرجى توقيع اسمك بالأسفل. **يتعين على الشخص الذي تبلغ عن هذه الشكوى له التوقيع أعلاه أو إخبار خطة الصحة الخاصة به\ابها أوبرنامج TennCare بأنه لا يوجد مانع من قيامك بالتوقيع له\الها. بيان**: أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج **TennCare** موافقتي للاتصال بي بشأن تلك الشكوى.

_____

(وقع هنا إن كنت تبلغ عن هذه الشكوى من أجل شخص آخر) (التاريخ)

هل أنت مساعد من برنامج TennCare أو خطة الصحة\ منظمة الرعاية المدارة التي تساعد العضو بنية طيبة لملء تلك الشكوى؟ إن كان الأمر كذلك، يرجى التوقيع بالأسفل:

_____ (وقع هنا إن كنت مساعد من

TennCare أو من خطة الصحة\ منظمة الرعاية المدارة) (التاريخ)

لا يوجد مانع من الإبلاغ عن أي شكوى لخطة الصحة\ منظمة الرعاية المدارة الخاصة بك أو برنامج TennCare. ويتم التعامل مع المعلومات المتضمنة في تلك الشكوى بسرية. ولا يتم مشاركة الأسماء وأي معلومات أخرى بشأن الأشخاص المستخدمين في تلك الشكوى إلا عند الحاجة. يرجى إرسال اتفاق الكشف عن المعلومات موقعًا مع شكوتك. وفي حال تقديمك لتلك الشكوى نيابة عن شخص آخر، فيتعين على هذا الشخص توقيع اتفاق الكشف عن المعلومات وارساله مع تلك الشكوى. احتفظ بنسخة من كل شيء ترسله. يرجى ارسال بريد أو بريد إلكتروني بالشكوى الموقعة والكاملة وصفحات اتفاق الكشف عن المعلومات الموقع لنا على:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

كما يمكنك الاتصال بنا إن احتجت للمساعدة بخصوص تلك المعلومات.

Division of TennCare

اتفاقية برنامج TennCare للإفصاح عن المعلومات

قد يحتاج برنامج TennCare من أجل التحقيق في شكواك إلى إطلاع أشخاص آخرين أو مؤسسات أخرى ذات أهمية بالنسبة لهذه الشكوى على اسمك أو معلومات أخرى عنك.

لتعجيل التحقيق في شكواك، احرص على قراءة نسخة من اتفاقية الإفصاح عن المعلومات هذه وتوقيعها وإرسالها بالبريد مع شكواك. ويُرجى الاحتفاظ بنسخة لنفسك.

- أفهم أنه أثناء التحقيق في شكواي، يجوز لبرنامج TennCare مشاركة اسمي أو تاريخ ميلادي أو معلومات المطالبات أو المعلومات الصحية أو غيرها من المعلومات المتعلقة بي مع أشخاص آخرين أو مؤسسات أخرى. وقد يحتاج برنامج TennCare إلى جمع هذه المعلومات عنك من بعض الأشخاص أو المؤسسات. فعلى سبيل المثال، إذا اشتكيت من أن طبيبي قد عاملني بطريقة مختلفة بسبب لوني، فقد يحتاج برنامج TennCare إلى التحدث إلى طبيبي والحصول على سجلاتي الطبية.

- لست مُلزمًا بالموافقة على الإفصاح عن اسمك أو أي معلومات أخرى. فقد لا تكون هذه المعلومات ضرورية في جميع الأوقات من أجل التحقيق في شكواك. وإذا لم توقع على اتفاقية الإفصاح، فسنستمر في محاولة التحقيق في شكواك. لكن يُرجى العلم أنه إذا لم توافق على السماح لنا باستخدام اسمك أو تفاصيل أخرى، فقد يؤدي ذلك إلى تقييد أو إيقاف التحقيق في شكواك. وقد نضطر إلى إغلاق حالتك. قبل إغلاق حالتك بسبب عدم توقيعك على اتفاقية الإفصاح، قد نتصل بك لمعرفة ما إذا كنت تريد توقيع اتفاقية إفصاح حتى يتسنى مواصلة التحقيق.

إذا كنت تقدم هذه الشكوى نيابة عن شخص آخر، فإننا بحاجة إلى توقيع هذا الشخص على اتفاقية الإفصاح عن المعلومات. هل توقع على هذه الاتفاقية بصفتك ممثلًا مفوضًا؟ في هذه الحالة، يجب عليك أيضًا أن تقدم لنا نسخة من وثائق تعيينك كممثل مفوض.

بالتوقيع على اتفاقية الإفصاح عن المعلومات هذه، أوافق على أنني قد قرأت وفهمت حقوقي المكتوبة أعلاه. كما أوافق على السماح لبرنامج TennCare بمشاركة اسمي أو معلومات أخرى عني مع أشخاص آخرين أو مؤسسات أخرى مهمة بالنسبة لهذه الشكوى أثناء التحقيق وحتى الوصول إلى النتيجة.

تسري اتفاقية الإفصاح عن المعلومات هذه حتى الوصول إلى النتيجة النهائية لشكواك. ويمكنك إلغاء الاتفاقية في أي وقت عن طريق الاتصال ببرنامج TennCare أو مراسلته كتابيًا ولن يؤدي ذلك إلى إلغاء شكواك. في حالة إلغاء الاتفاقية، لا يمكن منع المعرفة بالمعلومات التي تمت مشاركتها بالفعل.

التوقيع: _____ التاريخ: _____

الاسم (يُرجى الكتابة بحروف واضحة): _____

العنوان: _____

الهاتف: _____

هل تريد تقديم شكوى؟ يُرجى إرسال نموذج شكوى مُستوفى وموقع واتفاقية إفصاح عن المعلومات موقعة بالبريد إلى:

TennCare OCRC
الاتصالات 711)
310 Great Circle Road, 3W
Nashville, TN 37243

هاتف: 1-615-507-6474 أو مجانًا عبر 1-855-857-1673 (خدمة ترحيل

بريد إلكتروني:HCFA.fairtreatment@tn.gov

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: **کوردی**

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە
1- 855-259-0701 (1-800-848-0298) TTY بکە.

Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701
(رقم هاتف الصم والبكم:1-800-848-0298).

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701
（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-855-259-0701 (TTY: 1-800-848-0298).

Laotian:	**ພາສາລາວ**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).	
German:	**Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).	
Tagalog:	**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).	
Hindi:	**हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।	
Serbo-Croatian:	**Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).	
Russian:	**Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).	
Nepali:	**नेपाली**
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।	
Persian:	
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.	

- **هل تحتاج إلى مساعدة في التحدث إلينا أو قراءة ما نرسله إليك؟**
- **هل تعاني من إعاقة وتحتاج إلى المساعدة في الحصول على الرعاية أو المشاركة في أحد برامجنا أو خدماتنا؟**
- **أو هل لديك أسئلة أخرى بشأن رعايتك الصحية؟**

اتصل بنا مجانًا على 1-855-259-0701. يمكننا توصيلك بالمساعدة المجانية أو الخدمة التي تحتاجها.

(للاتصال عبر الهاتف النصي (TTY): 1-800-848-0298

ACKNOWLEDGMENT OF DISCLOSURE AND ACCEPTANCE OF
MEMBER FINANCIAL RESPONSIBILITY

CONSENT FORM

_____

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

_____

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

_____

Office/Location Name and Address

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

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

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

Date: _____

Signature of Member or Member's Legal

Representative

Witness:

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

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

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

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

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

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

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

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

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

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

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

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

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

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

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

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

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

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

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

PLACE OF TREATMENT

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

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

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

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

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

DENTAL EXAMINATION FORM

PART I: TO BE COMPLETED PRIOR TO VISIT

Client Name: _____ **Date:** _____

Frequency Oral Hygiene is Performed: ☐ once daily ☐ twice daily ☐ three times/ day
☐ Rarely/Not done related to uncooperative behavior

Method of Oral Hygiene: ☐ Independent, manual toothbrush ☐ Staff assist, manual toothbrush
☐ Independent, electric toothbrush ☐ Staff assist, electric toothbrush
☐ Flossing ☐ Not Flushing ☐ Oral Swabs

Gum Assessment: ☐ No bleeding associated with oral hygiene
☐ Bleeding sometimes associated with oral hygiene
☐ Bleeding always associated with oral hygiene

Signature of Caretaker Accompanying Client: _____

PART II: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Gingival Assessment: Maxilla _____
Mandible: _____

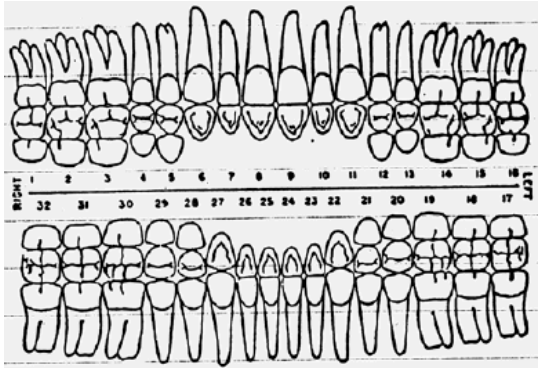
Growths: _____

Occlusion: _____

Ulcerations: _____

Dentures: _____Satisfactory _____Unsatisfactory

Other: _____



Tooth #	Problem	Recommendation	Intervention Performed

Services Rendered: ☐ Cleaning/ Prophylaxis ☐ X-ray ☐ Other: _____

Plan/ Recommendations: _____

HCP Signature: _____

Printed Name: _____

Date/Time of Next Appointment: _____

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.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

Health History Form

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

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

DentaQuest

Provider Update Form - Provider Operations

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

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

Change Effective Date *(Required)* :

*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, 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 DentaQuest can change your name 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

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: DentaQuest requires a Group NPI 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 DentaQuest 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

Section 10: Type of Update - Check all that Apply - *Complete for ALL Requests - Internal Use ONLY*

☐ Product(s) Add/ Update/ Term- **Complete Sections 1, 10 and Notes**

☐ Claims Issue(s) - **Complete Sections 1, 10 and Notes**

☐ Dental Home - **Complete Sections 1, 10 and Notes**

☐ Fee Schedule Add - **Complete Sections 1, 10 and Notes**

☐ Fee Schedule Change - **Complete Sections 1, 10 and Notes**

☐ Provider Rule Add - **Complete Sections 1, 10 and Notes**

☐ Provider Rule Change - **Complete Sections 1, 10 and Notes**

Notes

Provider Update Form - Provider Operations

Additional 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 _____

DentaQuest

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

***Indicates Required Field. Please print legibly.**

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	
Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	

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

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

Financial Institution Information			
*Financial Institution Name			
Financial Institution Address			
*Street		*City	
*State/Province		*Zip Code/Postal Code	
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

Authorized Signature

Requested EFT Start/Change/Cancel Date

Printed Name of Person Submitting Enrollment

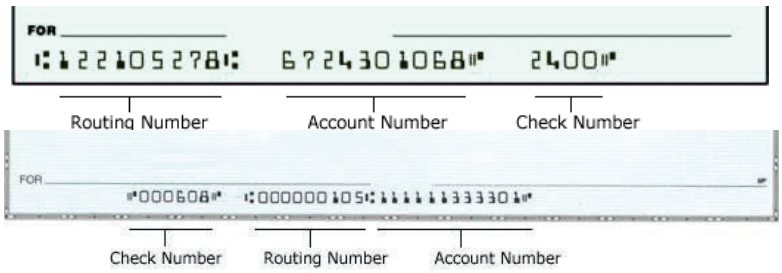
Printed Title of Person Submitting Enrollment

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

Business Checking Example

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

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

Requester's name and address (optional)

6 City, state, and ZIP code

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

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: _____

Address: _____

Phone: _____

Patient Refusal of Recommended Treatment Form

NAME OF INDIVIDUAL: _____DATE: _____

NAME OF MCO: _____

I,_____have chosen to refuse and not to consent to the dental treatment(s) that has been recommended to by my dental provider and the dental benefits manager for the State of Tennessee. All risks and benefits of the specific treatment has been explained to me, and I have elected to decline the service.

Reason for Refusal:

_____

_____

_____

_____

Individual/Guardian Signature Date

_____

Support Coordinator Signature Date

DentaQuest

Dental Case Management Form for Patients with Special Healthcare Needs

Required documentation for CDT D9997 Dental Case Management Patients with Special Healthcare Needs

Date: _____

Member Name:					Phone:		
Address:			City:		Zip Code:		
TennCare ID:		Sex at birth:		Age:		DOB:	
Qualifying Diagnosis							
Additional Diagnoses:							
Behavioral Assessment from Primary Care Physician							

Dental Office:				Dentist:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Medical Office:				Physician:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Legal Guardian:				Relation:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Caregiver:				Relation:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Logistical Considerations:				Agency:	
Transportation:				Contact:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	
Alternate Transportation:					

Motivational Interview a.) Ask opened ended questions b.) Affirm the patient's strengths c.) Reflective listening d.) Summarize what was stated e.) Conclude with an open ended statement f.) Inform and advise when appropriate and when patient and caregiver are ready for a change 1. Introduce patient, family, caregiver to office and treatment team. 2. Educate patients and families/caregiver on treatment options and plans. 3. Communicate with patients, family/caregiver on appointment times and required preparations. 4. Establish most effective communication modality/style.	
Chief Concerns:	
Home Care Needs/ Challenges & Compliance Barriers:	
Communication Style:	
Summary of Motivational Interview:	

Modifications Needed for Care Limitations and special treatment considerations that require modifications to delivery of treatment			
Physical:		Developmental:	
Medical:		Cognitive:	
Other:			
Treatment Sequencing Narrative on treatment plan per phase including tooth numbers or area			
Urgent Phase Acute issues such as pain, infection, broken or cracked teeth should be addressed immediately			
Control Phase Eliminates active disease such as caries and inflammation; eliminate conditions that prevent maintenance of healthy oral cavity. Begin preventive dentistry treatment. Focus on oral health home care with patient and caregiver			
Re-evaluation Phase Determine the response to the treatment that has been rendered at the tooth level and the patient level, and decide on any further treatment			
Definitive Phase Reassessment of patient's needs and determine if they require further care. This may involve referral to specialty care			

Maintenance Phase Provide continued preventive and periodontal care and reassess the patients' oral condition and determine if any new interventions are needed. Establish re-care maintenance schedule	

Oral Health Literacy Improvement Interview & Plan	
Chief Concerns:	
Summary of Oral Hygiene Interview:	
a) Home care routine description	
b) Is assistance required? Implements used? Rotary or manual toothbrush used?	
c) Daily frequency and timing of home care routine	
d) What have been the historical oral hygiene goals for patient	
e) Explain compliance barriers that affect consistent home hygiene	
Home Care Needs/ Challenges & Compliance Barriers:	
Caries Risk Assessment:	
Oral Hygiene Assessment & Diagnosis:	
Periodontal Risk Assessment (PRA):	
Periodontal Assessment & Diagnosis:	
Summary of Oral Hygiene Education (OHI that was presented to patient & care team using visual tools and technology for oral health education that is appropriate for special needs patients & their care team)	
Summary of the Oral Hygiene Plan discussion with guardian, caregivers & agency. Delineate areas of responsibility.	

Dentist Signature:	Printed Name:	Date:

DentaQuest

Medical Clearance & Sedation Clearance Form for Patients with Special Healthcare Needs

Required documentation for CDT D9997 Dental Case Management Patients with Special Healthcare Needs

Request Date _____

Member Name:					Phone:		
Address:				City:		Zip Code:	
TennCare ID:		Sex at birth:		Age:		DOB:	
Qualifying Diagnosis							
Additional Diagnoses:							
Allergies:							

Dental Office:				Dentist:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Medical Office:				Physician:	
Address:			City:		Zip Code:
Office Phone:		Fax:		Email:	

Reasons for request: (check all that apply)

☐	Failure of effective communication techniques and inability for immobilization (patient may be a danger to self or staff)
☐	Patient has acute situational anxiety due to immature cognitive functioning
☐	Patient is uncooperative due to certain physical or mental compromising conditions
☐	Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation
☐	Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient
☐	Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient
☐	Other (please list)

Your patient is being scheduled for dental procedures that may require the administration of local anesthesia. He/she may also require the administration of IV sedation or general anesthesia. Please review the clearance requested, the reasons checked below and complete the Primary Care Provider Response section to allow if it is safe for the patient.

Dental Provider, please check/circle the items below:

- ☐ Local Anesthesia (2% Xylocaine 1X100,000 epinephrine)
- ☐ Nitrous Oxide / Oxygen Analgesia
- ☐ Oral Sedation
- ☐ IV Sedation
- ☐ General Anesthesia in Hospital or Surgi-Center

Primary Care Provider Response: *Check all that apply*

☐	No contraindications for general anesthesia for dental procedure
☐	No special precautions needed for dental treatment
☐	No Prophylactic antibiotics needed
☐	Agree with dentist's medical or behavioral diagnosis as indication for: (circle one)

	Nitrous Oxide Analgesia ☐ Oral Sedation ☐ IV Sedation ☐ General Anesthesia ☐		
	Comments/Other:		
	Physician Signature:	Printed Name:	Date:

APPENDIX B – Covered Benefits

This section identifies TennCare Dental Program covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:**

855.418.1623

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

DentaQuest recognizes tooth number "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for 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, TennCare Dental Program Providers should bill only per unique surface regardless of location. For example, when a dentist places separate restorations in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA coded 2140. 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 in this manual. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

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

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

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

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

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 within 30 days 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.
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			No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0140	limited oral evaluation-problem focused			No	Two of (D0140) per 1 Year(s) Per Provider OR Location.	
D0150	comprehensive oral evaluation - new or established patient			No	One of (D0150) per Lifetime Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider.	
D0160	detailed and extensive oral evaluation			No	One of (D0120, D0145, D0150, D0160) per 6 Month(s) Per Provider OR Location.	
D0210	intraoral - complete series of radiographic images			No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image			No	One (1) Per Date of Service	
D0230	intraoral - periapical each additional radiographic image			No		
D0270	bitewing - single radiographic image			No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images			No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewings - three radiographic images			No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images			No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0330	panoramic radiographic image			No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	
D0367	Cone beam CT capture and interpretation with field of view of both			No	One of (D0210, D0330, D0367) per 36 Month(s) Per patient.	

	jaws, with or without cranium					

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

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

Preventive						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult			No	One of (D1110, D4910) per 6 Month(s) Per patient.	
D1206	topical application of fluoride varnish			No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish			No	One of (D1206, D1208) per 6 Month(s) Per patient.	
D1354	interim caries arresting medicament application - per tooth		Teeth 1 - 32	No	Four of (D1354) per 1 Lifetime Per patient, Same tooth.	

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty six months, unless there is recurrent
decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing,
and polishing are included as part of the fee for the restoration.

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

Unusual anatomic tooth/ surface combinations may include, but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration. Cases may be considered with photographic evidence of extent of decay or restoration.

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.

Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.

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		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2150	Amalgam - two surfaces, primary or permanent		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2160	amalgam - three surfaces, primary or permanent		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	

D2161	amalgam - four or more surfaces, primary or permanent		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2330	resin-based composite - one surface, anterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2331	resin-based composite - two surfaces, anterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2332	resin-based composite - three surfaces, anterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2391	resin-based composite - one surface, posterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2392	resin-based composite - two surfaces, posterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2393	resin-based composite - three surfaces, posterior		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2394	resin-based composite - four or		Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330,	

	more surfaces, posterior				D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient, Same tooth/Same surface.	
D2721	crown - resin with predominantly base metal		Teeth 1 - 32	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	
D2722	crown - resin with noble metal		Teeth 1 - 32	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	
D2740	crown - porcelain/ceramic		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2750	crown - porc/metal high noble		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2753	crown - porcelain fused to titanium and titanium alloys		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2781	crown - ¾ cast predominantly base metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2782	crown - ¾ cast noble metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791,	pre-operative x-ray(s)

					D2792) per 60 months per patient, same tooth.	
D2783	crown - ¾ porcelain/ceramic		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal		Teeth 1 - 32	Yes	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2791, D2792) per 60 months per patient, same tooth.	pre-operative x-ray(s)
D2920	re-cement or re-bond crown		Teeth 1 - 32	No	Not allowed within 6 months of initial placement.	
D2931	prefabricated stainless steel crown-permanent tooth		Teeth 1 - 32	No	One of (D2740, D2751, D2752, D2753, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2931, D2933, D2934) per 60 Month(s) Per patient, same tooth.	
D2991	application of hydroxyapatite regeneration medicament – per tooth		Teeth 1 - 32 , A-T	No	Four of (D1354, D2991) per 1 Lifetime Per patient, Same tooth. Six of (D1354, D2991) per Day(s) Per patient.	

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

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, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals,
intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

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)		Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)		Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)		Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient, Same tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for TN - Tenncare
Adult & Pregnancy/Postpartum Dental Program

Reimbursement includes local anesthesia, suturing if needed, and routine post operative care.

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**
D4341	periodontal scaling and root planing - four or more teeth per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient, Same quadrant.	
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit			No	One of (D4355) per 1 Lifetime Per patient.	
D4910	Periodontal maintenance			No	One of (D1110, D4910) per 6 Month(s) Per patient.	

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be
considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies
are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments or relines during the six (6) month period following delivery and routine post delivery care.

BILLING AND REIMBURSEMENT FOR COMPLETE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ON THE INSERTION/
CEMENTATION DATE.

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

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		Per Arch (01, UA)	Yes	One of (D5110) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular		Per Arch (02, LA)	Yes	One of (D5120) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary		Per Arch (01, UA)	Yes	One of (D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular		Per Arch (02, LA)	Yes	One of (D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)			Yes	One of (D5211, D5213 or D5282) per 60 months	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)			Yes	One of (D5212, D5214, or D5283) per 60 months	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)			Yes	One of (D5211, D5213 or D5282) per 60 months	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)			Yes	One of (D5212, D5214, or D5283) per 60 months	pre-operative x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary			Yes	One of (D5211, D5213 or D5282) per 60 months	pre-operative x-ray(s)

D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular			Yes	One of (D5212, D5214, or D5283) per 60 months	pre-operative x-ray(s)
D5284	removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant			Yes	One of (D5284 or D5286) per lifetime	pre-operative x-ray(s)
D5286	removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant			Yes	One of (D5284 or D5286) per lifetime	pre-operative x-ray(s)
D5611	repair resin partial denture base, mandibular			No	Not allowed within 6 months of delivery	
D5612	repair resin partial denture base, maxillary			No	Not allowed within 6 months of delivery	
D5621	repair - cast partial framework, mandibular			No	Not allowed within 6 months of delivery	
D5622	repair - cast partial framework, maxillary			No	Not allowed within 6 months of delivery	
D5630	repair - broken clasp partial denture			No	Not allowed within 6 months of delivery	
D5640	replace - missing/broken teeth - partial			No	Not allowed within 6 months of delivery	
D5650	add tooth - partial denture			No	Not allowed within 6 months of delivery	
D5660	add clasp - partial denture			No	Not allowed within 6 months of delivery	
D5730	reline complete maxillary denture (chairside)			No	One of (D5730, D5750) per 36 Month(s) Per patient.	
D5731	reline complete mandibular denture (chairside)			No	One of (D5731, D5751) per 36 Month(s) Per patient.	
D5750	reline complete maxillary denture (laboratory)			No	One of (D5730, D5750) per 36 Month(s) Per patient.	
D5751	reline complete mandibular denture (laboratory)			No	One of (D5731, D5751) per 36 Month(s) Per patient.	

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated
malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)		Teeth 1 - 32	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		Teeth 1 - 32	Yes	Includes cutting of gingiva and bone, removal of tooth structure and closure.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue		Teeth 1 - 32	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)		Teeth 1 - 32, 51 - 82	Yes	Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7284	excisional biopsy of minor salivary glands			No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient, Same quadrant.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient, Same quadrant.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to		Per Quadrant (10, 20, 30,	Yes	One of (D7320, D7321) per 1 Lifetime Per patient, Same quadrant.	pre-operative x-ray(s)

	three teeth or tooth spaces, per quadrant		40, LL, LR, UL, UR)			
D7471	removal of exostosis - per site		Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus			Yes		narrative of medical necessity
D7473	removal of torus mandibularis			Yes		narrative of medical necessity
D7485	surgical reduction of osseous tuberosity			Yes		narrative of medical necessity

Exhibit A Benefits Covered for TN - Tenncare Adult & Pregnancy/Postpartum Dental Program

Reimbursement includes local anesthesia.

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure			No	One of (D9110) per Day(s) Per Provider OR Location.	
D9230	Inhalation of nitrous oxide/ analgesia			No	One (1) Per Date of Service. Narrative of medical necessity kept in patient record.	

Exhibit B **Benefits Covered for TN - TennCare**
Individuals with Intellectual & Developmental Disabilities (IDD) Programs

The following benefits are supplementary benefits covered only for members enrolled in the ECF CHOICES/1915(c) Waiver programs. These benefits are in addition to the primary coverage provided by the Adult Dental program.

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 within 30 days 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.
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**
D0170	re-evaluation, limited problem focused			Yes		
D0240	intraoral - occlusal radiographic image			Yes		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector			Yes		
D0251	extra-oral posterior dental radiographic image			Yes		
D0277	vertical bitewings - 7 to 8 films			Yes		
D0322	tomographic survey			Yes		
D0340	cephalometric radiographic image			Yes		
D0460	pulp vitality tests			Yes		
D0470	diagnostic casts			Yes		

Exhibit B Benefits Covered for TN - TennCare
Individuals with Intellectual & Developmental Disabilities (IDD) Programs

The following benefits are supplementary benefits covered only for members enrolled in the ECF CHOICES/1915(c) Waiver programs. These benefits are in addition to the primary coverage provided by the Adult Dental program.

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty six months, unless there is recurrent
decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing,
and polishing are included as part of the fee for the restoration.

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

Unusual anatomic tooth/ surface combinations may include, but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration. Cases may be considered with photographic evidence of extent of decay or restoration.

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.

Post-cementation radiographs must be in the patient's chart and available for review upon request. Absence of radiographic evidence required for confirming the quality of restoration(s) in a patient's chart may result in the recovery of prior payments for the service.

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**
D2390	resin-based composite crown, anterior		Teeth 6 - 11, 22 - 27, C - H, M - R	Yes		
D2710	crown - resin-based composite (indirect)		Teeth 1 - 32	Yes		
D2932	prefabricated resin crown		Teeth 1 - 32, A - T	Yes		
D2933	prefabricated stainless steel crown with resin window		Teeth 1 - 32, A - T	Yes		
D2940	protective restoration		Teeth 1 - 32, A - T	Yes		
D2950	core buildup, including any pins when required		Teeth 1 - 32	Yes		

D2951	pin retention - per tooth, in addition to restoration		Teeth 1 - 32	Yes		
D2952	cast post and core in addition to crown		Teeth 1 - 32	Yes		
D2953	each additional cast post - same tooth		Teeth 1 - 32	Yes		
D2954	prefabricated post and core in addition to crown		Teeth 1 - 32	Yes		
D2955	post removal (not in conjunction with endodontic therapy)		Teeth 1 - 32	Yes		
D2957	each additional prefabricated post - same tooth		Teeth 1 - 32	Yes		
D2980	crown repair, by report		Teeth 1 - 32	Yes		

Exhibit B Benefits Covered for TN - TennCare
Individuals with Intellectual & Developmental Disabilities (IDD) Programs

The following benefits are supplementary benefits covered only for members enrolled in the ECF CHOICES/1915(c) Waiver programs. These benefits are in addition to the primary coverage provided by the Adult Dental program.

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, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals,
intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

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		Teeth 1 - 32, A - T	Yes		
D3221	pulpal debridement, primary and permanent teeth		Teeth 1 - 32, A - T	Yes		
D3331	treatment of root canal obstruction; non-surgical access		Teeth 1 - 32	Yes		
D3332	incomplete endodontic therapy; inoperable or fractured tooth		Teeth 1 - 32	Yes		
D3333	internal root repair of perforation defects		Teeth 1 - 32	Yes		
D3346	retreatment of previous root canal therapy-anterior		Teeth 6 - 11, 22 - 27	Yes		
D3347	retreatment of previous root canal therapy - premolar		Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes		
D3348	retreatment of previous root canal therapy-molar		Teeth 1 - 3, 14 - 19, 30 - 32	Yes		
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)		Teeth 1 - 32	Yes		

D3352	apexification/recalcification - interim medication replacement		Teeth 1 - 32	Yes		
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)		Teeth 1 - 32	Yes		
D3410	apicoectomy - anterior		Teeth 6 - 11, 22 - 27	Yes		
D3421	apicoectomy - premolar (first root)		Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes		
D3425	apicoectomy - molar (first root)		Teeth 1 - 3, 14 - 19, 30 - 32	Yes		
D3426	apicoectomy (each additional root)		Teeth 1 - 5, 12 - 21, 28 - 32	Yes		
D3430	retrograde filling - per root		Teeth 1 - 32	Yes		
D3450	root amputation - per root		Teeth 1 - 32	Yes		
D3921	De-coronation or submergence of an erupted tooth		Teeth 1 - 32	Yes		

Exhibit B Benefits Covered for TN - TennCare
Individuals with Intellectual & Developmental Disabilities (IDD) Programs

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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		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation			Yes		

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A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be
considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies
are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments or relines during the six (6) month period following delivery and routine post delivery care.

BILLING AND REIMBURSEMENT FOR COMPLETE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ON THE INSERTION/
CEMENTATION DATE.

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

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**
D5225	maxillary partial denture-flexible base			Yes		
D5226	mandibular partial denture-flexible base			Yes		
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth			Yes		
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)			Yes		
D5410	adjust complete denture - maxillary			Yes		
D5411	adjustment - complete denture - mand			Yes		
D5421	adjust partial denture-maxillary			Yes		
D5422	adjust partial denture - mandibular			Yes		
D5511	repair broken complete denture base, mandibular			Yes		
D5512	repair broken complete denture base, maxillary			Yes		
D5520	replace missing or broken teeth - complete denture (each tooth)			Yes	Teeth 1 - 32	
D5670	replace all teeth and acrylic on cast metal framework (maxillary)			Yes		

D5671	replace all teeth and acrylic on cast metal framework (mandibular)			Yes		
D5710	rebase complete maxillary denture			Yes		
D5711	rebase complete mandibular denture			Yes		
D5720	rebase maxillary partial denture			Yes		
D5721	rebase mandibular partial denture			Yes		
D5725	rebase hybrid prosthesis			Yes		
D5740	reline maxillary partial denture (chairside)			Yes		
D5741	reline mandibular partial denture (chairside)			Yes		
D5760	reline maxillary partial denture (laboratory)			Yes		
D5761	reline mandibular partial denture (laboratory)			Yes		
D5761	soft liner for complete or partial removable denture - indirect			Yes		
D5810	interim complete denture-maxillary			Yes		
D5811	interim complete denture-mandibular			Yes		
D5820	interim partial denture (maxillary)			Yes		
D5821	interim partial denture-mandibular			Yes		
D5850	tissue conditioning, maxillary			Yes		
D5851	tissue conditioning,mandibular			Yes		
D5862	precision attachment, by report			Yes	Teeth 1 - 32	
D5863	Overdenture - complete maxillary			Yes		
D5864	Overdenture - partial maxillary			Yes		
D5865	Overdenture - complete mandibular			Yes		
D5866	Overdenture - partial mandibular			Yes		
D5867	Replacement of replaceable part of semi-precision attachment			Yes	Teeth 1 - 32	
D5876	add metal substructure to acrylic full denture (per arch)			Yes	Per Arch (01, 02, LA, UA)	

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Prosthodontics, Fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6211	pontic-cast base metal		Teeth 1 - 32	Yes		
D6212	pontic - cast noble metal		Teeth 1 - 32	Yes		
D6241	pontic-porcelain fused to base metal		Teeth 1 - 32	Yes		
D6242	pontic-porcelain fused-noble metal		Teeth 1 - 32	Yes		
D6243	pontic-porcelain fused to titanium and titanium alloys		Teeth 1 - 32	Yes		
D6245	prosthodontics fixed, pontic - porcelain/ceramic		Teeth 1 - 32	Yes		
D6251	pontic-resin with base metal		Teeth 1 - 32	Yes		
D6252	pontic-resin with noble metal		Teeth 1 - 32	Yes		
D6545	retainer - cast metal fixed		Teeth 1 - 32	Yes		
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic		Teeth 1 - 32	Yes		
D6721	crown-resin with base metal		Teeth 1 - 32	Yes		
D6722	crown-resin with noble metal		Teeth 1 - 32	Yes		
D6740	retainer crown – porcelain/ceramic		Teeth 1 - 32	Yes		
D6751	crown-porcelain fused to base metal		Teeth 1 - 32	Yes		
D6752	crown-porcelain fused noble metal		Teeth 1 - 32	Yes		
D6753	retainer crown - porcelain fused to titanium and titanium alloys		Teeth 1 - 32	Yes		
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal		Teeth 1 - 32	Yes		
D6782	prosthodontics fixed, crown ¾ cast noble metal		Teeth 1 - 32	Yes		
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic		Teeth 1 - 32	Yes		

D6784	retainer crown 3/4 - titanium and titanium alloys		Teeth 1 - 32	Yes		
D6791	crown - full cast base metal		Teeth 1 - 32	Yes		
D6792	crown - full cast noble metal		Teeth 1 - 32	Yes		
D6920	connector bar		Per Arch (01, 02, LA, UA)	Yes		
D6930	re-cement or re-bond fixed partial denture			Yes		
D6940	stress breaker		Teeth 1 - 32	Yes		
D6950	precision attachment		Teeth 1 - 32	Yes		
D6980	fixed partial denture repair		Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		

Exhibit B Benefits Covered for TN - TennCare
Individuals with Intellectual & Developmental Disabilities (IDD) Programs

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Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated
malocclusion causing a shifting of existing dentition.

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

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony		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		
D7240	removal of impacted tooth-completely bony		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		
D7241	removal of impacted tooth-completely bony, with unusual surgical complications		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		
D7260	oroantral fistula closure			Yes		

D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		Teeth 1 - 32	Yes		
D7272	tooth transplantation (inlcudes reimplantation from one site to another)		Teeth 1 - 32	Yes		
D7280	Surgical access of an unerupted tooth		Teeth 1 - 32	Yes		
D7282	mobilization of erupted or malpositioned tooth to aid eruption		Teeth 1 - 32	Yes		
D7285	incisional biopsy of oral tissue-hard (bone, tooth)			Yes		
D7286	incisional biopsy of oral tissue-soft			Yes		
D7410	radical excision - lesion diameter up to 1.25cm			Yes		
D7413	excision of malignant lesion up to 1.25 cm			Yes		
D7440	excision of malignant tumor - lesion diameter up to 1.25cm			Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm			Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm			Yes		
D7465	destruction of lesion(s) by physical or chemical method, by report			Yes		
D7510	incision and drainage of abscess - intraoral soft tissue		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		
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)			Yes		

D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue			Yes		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system			Yes		
D7880	occlusal orthotic device, by report			Yes		
D7970	excision of hyperplastic tissue - per arch		Per Arch (01, 02, LA, UA)	Yes		
D7971	excision of pericoronal gingiva		Teeth 1 - 32	Yes		
D7972	surgical reduction of fibrous tuberosity			Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar			Yes		

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Reimbursement includes local anesthesia.

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

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9210	local anesthesia not in conjuction with operative or surgical procedures			Yes		
D9211	regional block anesthesia			Yes		
D9212	trigeminal division block anesthesia			Yes		
D9215	local anesthesia in conjunction with operative or surgical procedures			Yes		
D9222	deep sedation/general anesthesia first 15 minutes			Yes		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment			Yes		
D9239	intravenous moderate (conscious) sedation/analgesia-first 15 minutes			Yes		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment			Yes		
D9248	non-intravenous moderate (conscious) sedation			Yes		
D9610	therapeutic drug injection, by report			Yes		
D9630	other drugs and/or medicaments, by report			Yes		
D9910	application of desensitizing medicament			Yes		
D9911	application of desensitizing resin for cervical and/or root surface, per tooth		Teeth 1 - 32	Yes		
D9939	placement of a custom removable clear plastic			Yes		

	temporary aesthetic appliance					
D9944	occlusal guard--hard appliance, full arch		Per Arch (01, 02, LA, UA)	Yes		
D9945	occlusal guard--soft appliance full arch		Per Arch (01, 02, LA, UA)	Yes		
D9946	occlusal guard - hard appliance, partial arch			Yes		
D9971	odontoplasty 1-2 teeth; includes removal of enamel projections		Teeth 1 - 32	Yes		
D9997	Dental case management -patients with special healthcare needs			Yes	One per lifetime per member per provider	Narrative of medically necessity