CHILD HEALTH PLAN PLUS (CHP+)

Office Reference Manual

PO Box 2906
Milwaukee, WI 53201-2906
855.225.1731
www.dentaquest.com

Dentaquest Address and Phone Numbers

Provider Services
P.O Box 2906
Milwaukee, WI 53201-2906
855.225.1731

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

Claims Questions
denclaims@dentaquest.com

Eligibility or Benefits Questions
denelig.benefits@dentaquest.com
To reach IVR directly, dial 855.398.8411 and press 1 for eligibility

Electronic Claim Questions
EDITeam@greatdentalplans.com
1.800.417.7140

Member Services
888.307.6561
Hearing Impaired/TTY:TDD (Hearing Impaired)
Dial 711
Fraud Hotline
800.237.9139

Authorizations Should be sent to
DENTAQUEST - CO
PO BOX 2906
Milwaukee, WI 53201-2906
Claims Should be sent to
DENTAQUEST– Co
P.O Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent to:
Direct entry on the web- www.dentaquest.com

OR

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

DentaQuest USA Insurance Company,Inc (DentaQuest) Overview

DentaQuest and The Department of Health Care Policy and Financing (“HCPF” or “the Department”) periodically modifies the dental benefits and services. Therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

Statement of Members Rights and Responsibilities

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

1. All members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as member's rights and responsibilities.
2. All members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.
3. All members have the right to fully participate with caregivers in the decision-making process surrounding their health care.
4. All members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
5. All members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
6. All members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.
7. All members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.
8. All members have the right to ask that a specific Provider be added to the participating network.
9. All members have the right to request and receive a copy of your medical /dental records and to request that they be changed or corrected.
10. All members have the right to exercise your rights without being treated differently.
11. All members have the right to be free from any form of restraint or seclusion used to convince you to do something you may not want to do, or as punishment.
12. All members have the right to have furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services.

Likewise:

1. All members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating Providers need in order to provide the highest quality of health care services.
2. All members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
3. All members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.
4. All members have the responsibility to know their medications and inform the Provider of their medication.
5. All members have the responsibility to make sure to understand information and instructions given by your Provider.
6. All members have the responsibility to be courteous to the Provider and to other patients by arriving 10 minutes early for their appointment and to call the dental office at least 24 hours in advance if they cannot keep their appointment.

Statement of Providers Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including members regarding dental treatment options.
2. Recommend a course of treatment to a member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, information to a member in connection with an appeal or complaint filed by the member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the Participating Provider must notify the member in writing and obtain a signature of waiver if the Provider intends to charge the member for such a non-compensable service.

Providers shall have the responsibility to:

1. Providers shall assist current and newly enrolled members (including the authorized family members or guardian) who may require additional dental services or complex dental treatment by referring them to in-network providers for emergency, urgent, routine, or specialized care based on the members needs and medical necessity.
2. Providers shall share member dental records as appropriate with other dental providers involved with a specific member's care.
3. Providers shall assess members who present for services for any special healthcare needs related to dental care.
    a. A dental member with special needs is defined as someone with medical, physical, psychological, or social circumstances that requires a provider to change their standard dental care and/or location or service to accommodate the member.
    b. An assessment can include special health care needs, mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. If the results of the assessment warrant it, providers may ask DentaQuest to coordinate care.
    c. Providers are required to create and update a member service/treatment plan according to the member’s changing needs.

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

DentaQuest's Commitment Culturally Competent Care

DentaQuest is committed to ensuring that its staff and participating providers, as well as its policies and infrastructure meet the diverse needs of all members and follows National Standards on Culturally and Linguistically Appropriate Services (CLAS).

DentaQuest requires its providers to adopt all fifteen National Standards on Culturally and Linguistically Appropriate Services ("CLAS Standards") in health care to promote equity through clear plans and strategies, eliminate health disparities, and improve the quality of services and primary care outcomes for members.

Principal CLAS Standard

CLAS Standard One: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Cultural competence impacts every aspect of care and service throughout the organization including all dental plans and the provider network.

Theme one — Governance, Leadership, and Workforce

CLAS Standard Two: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

CLAS Standard Three: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

CLAS Standard Four: Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

The cornerstone of the Cultural Competency Program is the commitment to establishing clinical, network, and operational policies to support ongoing assessment and improvement of health equity. DentaQuest believes that recruiting a workforce and provider network that reflect the communities in which it operates ensures that members feel welcome and that their values are respected.

Theme two — Communication and Language Assistance

CLAS Standard Five: Offer language assistance, at no cost, to individuals who have limited-English proficiency and/or other communication needs in order to facilitate timely access to health care and services.

CLAS Standard Six: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Language assistance options are available in many different languages and dialects and are available at no cost to the member, including in provider offices.

CLAS Standard Seven: Ensure the competence of individuals providing language assistance and recognize that the use of untrained individuals and/or minors as interpreters should be avoided. DentaQuest contracts with Certified Languages International to accommodate enrollees that speak other languages. In addition, DentaQuest has dedicated TTY lines during to assist hearing impaired callers.

CLAS Standard Eight: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. To ensure materials are culturally appropriate and meet cultural competency requirements, an internal team reviews all materials available to members. The review is conducted by subject-matter experts in Compliance, Complaints & Grievances, Client Engagement, Legal and other departments as necessary.

Theme three — Engagement, Continuous Improvement, and Accountability

CLAS Standard Nine: Establish culturally and linguistically appropriate goals, policies and management accountability and infuse them throughout the organization's planning and operations.

CLAS Standard Ten: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

CLAS Standard Eleven: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and inform service delivery.

Providers are surveyed quarterly to determine their cultural capabilities and sensitivity to cultural awareness such as whether they can speak languages other than English, treat special needs enrollees, and accommodate handicapped enrollees. In developing the surveys, DentaQuest considers the cultural, ethnic, racial, and linguistic needs of the members and the providers that serve our members. This in-depth analysis allows DentaQuest to review and update service programs, processes, and resources to address the health care needs of members. In accordance with the federal law, protected health information is kept safe for our members, and we inform our members of what we do to keep it safe in writing or on the computer.

CLAS Standard Twelve: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

CLAS Standard Thirteen: Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

CLAS Standard Fourteen: Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

CLAS Standard Fifteen: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Nondiscrimination Notice

DentaQuest complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DentaQuest does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DentaQuest:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please call customer service 1-855-225-1729.

If you believe that DentaQuest has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Ugonna Onyekwu
Civil Rights Coordinator
Compliance Department
465 Medford Street
Boston, MA 02159
Fax: 617-886-1390
Phone: 617-886-1683 TTY: 711
Email: FairTreatment@greatdentalplans.co

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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1.00 Colorado Child Health Plan Plus Benefit

Child Health Plan Plus members receive up to $1,000 in dental benefits per calendar year (January 1 through December 31) Each member will be assigned to one of three subgroups ($0 copay, $5 copay, $10 copay). Copays are paid per service by the member. Preventative and diagnostic services are not subject to a copay. Please refer to Exhibit A for the breakdown of covered procedures.

To determine accurate member co-pay information, please refer to the DentaQuest provider portal (or call DentaQuest customer service) instead of the Health First Colorado provider portal.

2.00 Patient Eligibility Verification Procedures

2.01 Plan Eligibility

Any person who is enrolled in a Child Health Plan Plus program is eligible for dental benefits. The member's County Department of Human/Social Services establishes member eligibility for Child Health Plan Plus dental benefits. Case managers advise potential members of proper application procedures and Child Health Plan Plus benefits, and they also provide a brochure. To find a list of Healthy Communities, go to https://www.colorado.gov/hcpf/family-health-coordinator-list and to find a list of Colorado Human Services in your county, go to https://www.colorado.gov/pacific/cdhs/contact-your-county

2.02 Member Identification

After member eligibility is established, the county issues a unique State Identification (State ID) number and members receive identification cards from DentaQuest. Participating Providers are responsible for verifying that members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Always verify eligibility **before** rendering services

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

It is important to note that the DentaQuest identification card is not dated, and it does not need to be returned to DentaQuest should a member lose eligibility. Therefore, an identification card in itself does not guarantee that a person is currently enrolled in DentaQuest.

Sample of I.D. Card

2.03 Verifying Member Eligibility and Managed Care Assignment Details

Verifying Eligibility and Managed Care Assignment Details

All providers are reminded to verify member eligibility prior to rendering service. Records of eligibility should be retained for billing purposes. It is critical for providers to always check the eligibility response on the day of each visit as eligibility may change. Eligibility verification is available electronically, 24 hours a day, 7 days a week. Eligibility information is updated daily, except for weekends and State holidays.

Obtaining prior authorization is not a guarantee of eligibility, enrollment, or payment.

Health First Colorado Provider Web Portal

Providers are required to verify eligibility for each date of service through the Health First Colorado web portal managed by the fiscal agent, Gainwell Technologies, using either the Provider Web Portal or via batch X12N 270. This portal is the system of record for member eligibility, not the DentaQuest Portal.

To access the Provider Web Portal, go to this link:
https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider/Home/tabid/135/Default.aspx.

For more information on how to verify member eligibility in the Provider Web Portal, refer to the Verifying Member Eligibility and Co-Pay Provider Web Portal Quick Guide by going to this link: https://www.colorado.gov/pacific/hcpf/verifying-eligibility-quickguide.

Appealing Claim Denials for Eligibility
If a claim is denied for eligibility by DentaQuest, the provider may appeal by submitting proof of eligibility obtained from the Health First Colorado provider portal (screenshot must be taken on Date Of Service). The appeal process is detailed in ORM section 7.0.

NOTE: On rare occasions, due to member eligibility requirements/qualifications, a member may initially show as enrolled in Medicaid and eligibility CHP+ enrollment by Health Care Policy and Financing (or vice versa).

Providers must check the Managed Care Assignment Details box on the Health First Colorado Provider Portal verification page to determine member enrollment and eligibility.

The following language will appear:

For the Managed Care Plan for Medicaid: “Administrative Service Organization Dental”
The Provider Name for Medicaid will appear as: “DentaQuest USA Insurance Co Inc”

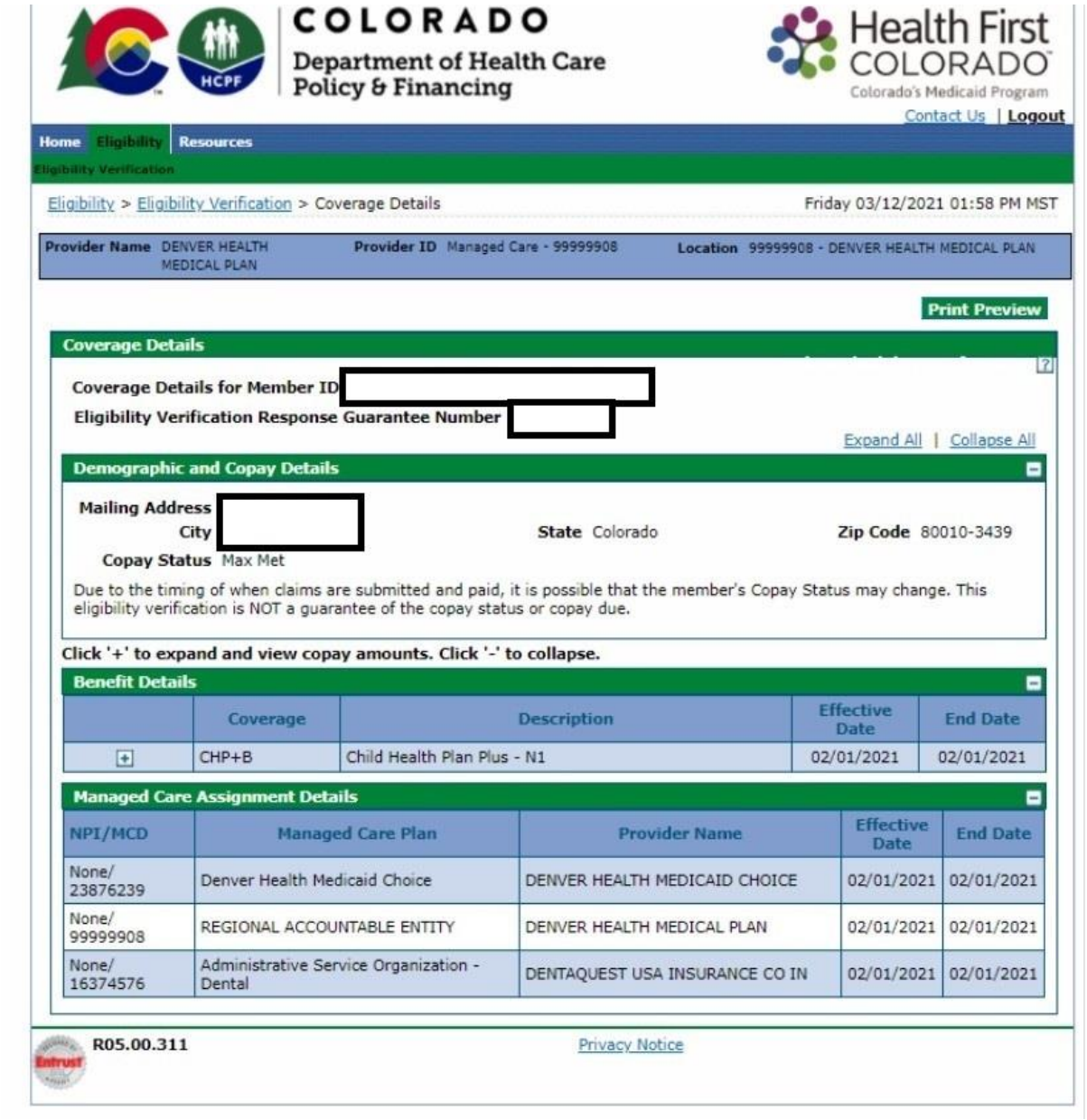
OR

For the Managed Care Plan for CHP+: “Child Health Plan Plus- Dental”

The Provider Name for CHP+ will appear as: “DentaQuest USA”
(If “DentaQuest USA” does not appear in this box, then the member does not currently have dental coverage and claims will not be processed. When a member is enrolled in either program, they are eligible for medical coverage immediately, but **dental coverage can take up to 30 days to be effective**.)

See the examples below:
Example #1: This record shows the member is eligible for Medicaid but is still enrolled in CHP+. (“Medicaid” appears in the Benefit Details section, however, “CHP+” appears in the Managed Care Assignment Details box. This claim will pay under CHP+ because the member is still enrolled in that program).

Example #2: This record shows the member is eligible for CHP+, but is still enrolled in Medicaid. ("CHP+" appears in the Benefit Details section, however, "Medicaid" is indicated in the Managed Care Assignment Details box. This claim will pay under Medicaid because the member is still enrolled in that program.)



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Health First COLORADO
Colorado's Medicaid Program

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Eligibility Verification

Eligibility > Eligibility Verification > Coverage Details — Friday 03/12/2021 01:58 PM MST

Provider Name DENVER HEALTH MEDICAL PLAN **Provider ID** Managed Care - 99999908 **Location** 99999908 - DENVER HEALTH MEDICAL PLAN

Print Preview

Coverage Details

Coverage Details for Member ID [redacted]

Eligibility Verification Response Guarantee Number [redacted]

Expand All | Collapse All

Demographic and Copay Details

Mailing Address [redacted]

City [redacted] **State** Colorado **Zip Code** 80010-3439

Copay Status Max Met

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

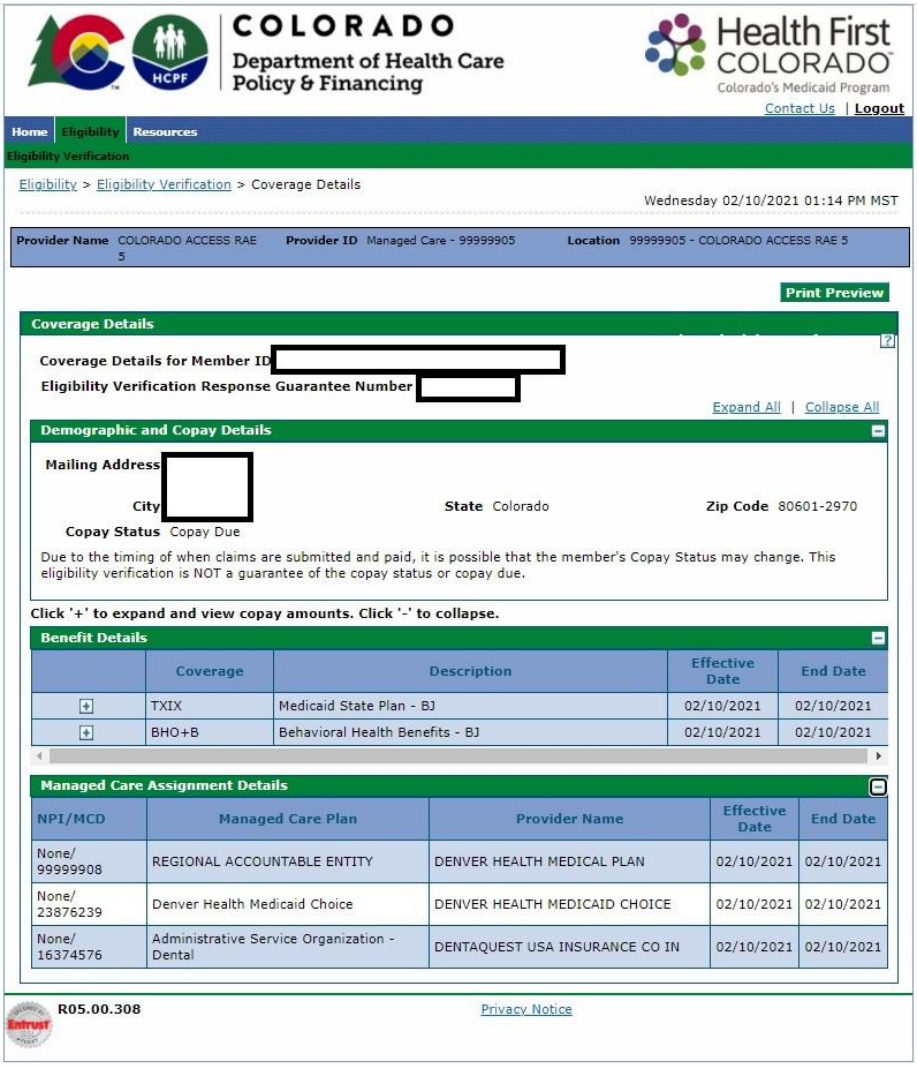
	Coverage	Description	Effective Date	End Date
⊞	CHP+B	Child Health Plan Plus - N1	02/01/2021	02/01/2021

Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 23876239	Denver Health Medicaid Choice	DENVER HEALTH MEDICAID CHOICE	02/01/2021	02/01/2021
None/ 99999908	REGIONAL ACCOUNTABLE ENTITY	DENVER HEALTH MEDICAL PLAN	02/01/2021	02/01/2021
None/ 16374576	Administrative Service Organization - Dental	DENTAQUEST USA INSURANCE CO IN	02/01/2021	02/01/2021

R05.00.311 Privacy Notice

Example #3: This example demonstrates eligibility and enrollment for Medicaid. (“Medicaid” appears in the Benefit Details section and “Medicaid” also appears in the Managed Care Assignment Details box):



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Eligibility Verification

Eligibility > Eligibility Verification > Coverage Details

Wednesday 02/10/2021 01:14 PM MST

Provider Name COLORADO ACCESS RAE 5 **Provider ID** Managed Care - 99999905 **Location** 99999905 - COLORADO ACCESS RAE 5

Print Preview

Coverage Details

Coverage Details for Member ID [redacted]

Eligibility Verification Response Guarantee Number [redacted]

Expand All | Collapse All

Demographic and Copay Details

Mailing Address [redacted]

City [redacted] **State** Colorado **Zip Code** 80601-2970

Copay Status Copay Due

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
+	TXIX	Medicaid State Plan - BJ	02/10/2021	02/10/2021
+	BHO+B	Behavioral Health Benefits - BJ	02/10/2021	02/10/2021

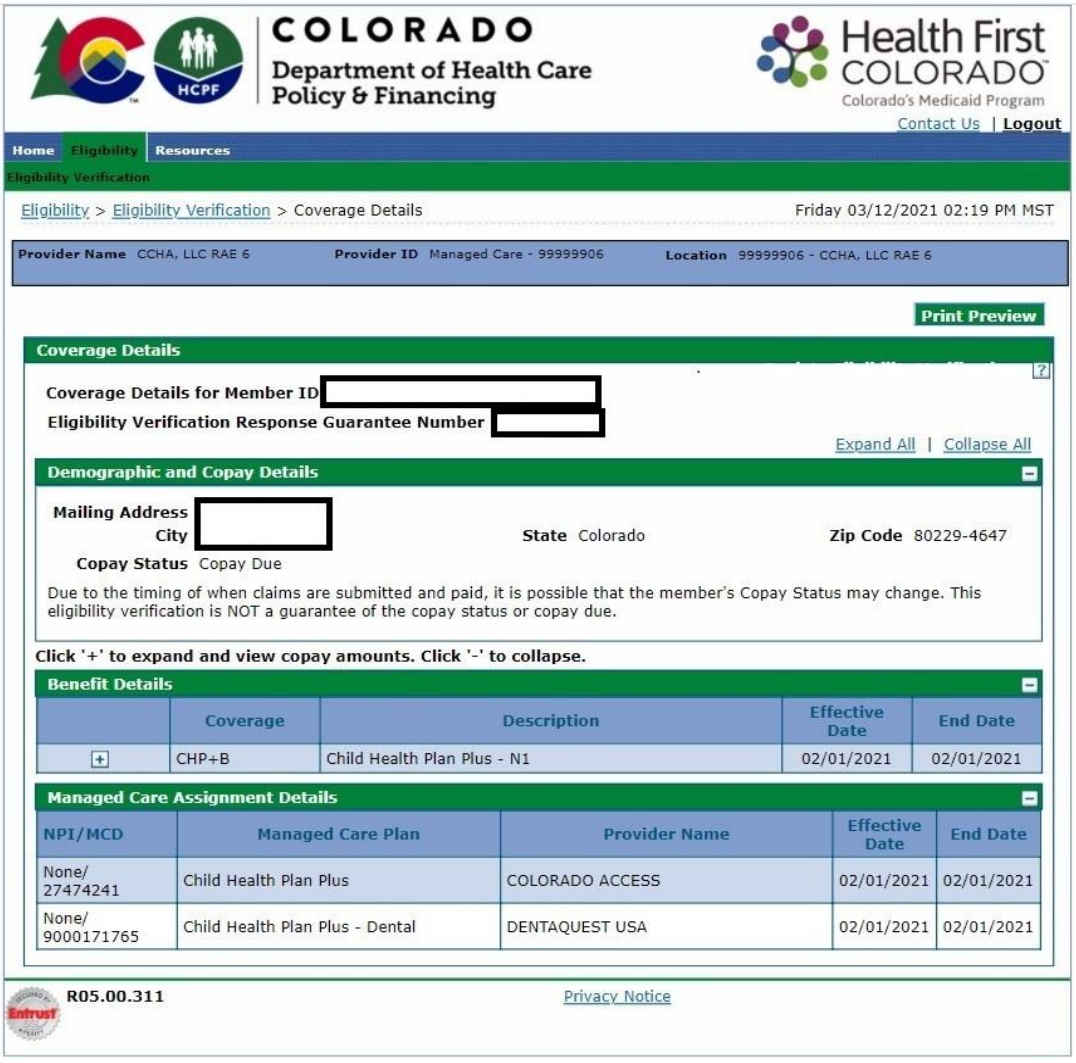
Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 99999908	REGIONAL ACCOUNTABLE ENTITY	DENVER HEALTH MEDICAL PLAN	02/10/2021	02/10/2021
None/ 23876239	Denver Health Medicaid Choice	DENVER HEALTH MEDICAID CHOICE	02/10/2021	02/10/2021
None/ 16374576	Administrative Service Organization - Dental	DENTAQUEST USA INSURANCE CO IN	02/10/2021	02/10/2021

R05.00.308

Privacy Notice

Example #4": This record is valid proof of eligibility and enrollment for CHP+. ("CHP+" appears in the Benefit Details section and "CHP+" also appears in the Managed Care Assignment Details box)



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Eligibility Verification

Eligibility > Eligibility Verification > Coverage Details — Friday 03/12/2021 02:19 PM MST

Provider Name CCHA, LLC RAE 6 **Provider ID** Managed Care - 99999906 **Location** 99999906 - CCHA, LLC RAE 6

Print Preview

Coverage Details

Coverage Details for Member ID [redacted]

Eligibility Verification Response Guarantee Number [redacted]

Expand All | Collapse All

Demographic and Copay Details

Mailing Address [redacted]
City [redacted] **State** Colorado **Zip Code** 80229-4647
Copay Status Copay Due

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
+	CHP+B	Child Health Plan Plus - N1	02/01/2021	02/01/2021

Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 27474241	Child Health Plan Plus	COLORADO ACCESS	02/01/2021	02/01/2021
None/ 9000171765	Child Health Plan Plus - Dental	DENTAQUEST USA	02/01/2021	02/01/2021

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Contact a Provider Relations Representative for questions regarding this process:

Northeastern Colorado
Natalie Archuleta
Natalie.Archuleta@dentaquest.com
Phone: 303-241-5183

Southeastern Colorado
Madison Lehman
Madison.Lehman@dentaquest.com
Phone: 720-985-1167

Central/Metro Denver
Davis Edge
Davis.Edge@dentaquest.com
Phone: 720-985-1167

Western Colorado
Cristal Chavez
Cristal.Chavez@dentaquest.com
Phone: 970-210-6250

DentaQuest Provider Portal

Participating Providers may access member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.dentaquest.com. Eligibility information is updated daily from files sent by Child Health Plan Plus, except for weekends and State holidays. The eligibility information received from the DentaQuest Provider Portal will be the same information received by calling DentaQuest's Customer Service department. Providers may use the provider portal to obtain 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 Provider Portal allows Providers to view a member's eligibility as well as submit claims directly to DentaQuest. Providers can view the member's eligibility online by entering the member's date of birth, the expected date of service and the member's identification number or last name and first initial. Eligibility information is accessed via DentaQuest's website, by navigating to the website at www.dentaquest.com, clicking on "Dentist", choosing the appropriate '"State" and pressing go. Providers will then be able to log in using their password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Providers who have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Service Department at 855.225.1731. After logging in, providers may select "eligibility look up" and enter the applicable information for the member to view eligibility status.

Access to Eligibility Information via the Interactive Voice Response (IVR) Line
To access the IVR, providers may call DentaQuest's Customer Service Department at 855.398.8411.

At the prompt, enter your NPI number the last 4 digits of your Tax ID Numbers. The remainder of the IVR system is activated by voice prompts.

DentaQuest IVR system can provide the following information:

- Eligibility (prompt 1)
- Benefits or history (prompt 2)
- Claims (prompt 3)
- Authorizations (prompt 4)
- Web portal Other (prompt 6)
- help (prompt 5)

Always verify eligibility with the Health First Colorado provider portal before rendering services. Please note that due to possible eligibility status changes, verification of eligibility information by either system is not a guarantee of payment.

If you are having difficulty accessing either the IVR or website, please contact the Provider Service Department at 855.225.1731. They will be able to assist you in utilizing either system.

2.04 Child Health Plan Plus Eligibility Verification Eligibility

The Child Health Plan Plus eligibility database is known as Colorado Benefits Management System (CBMS). Eligibility verification is available electronically 24 hours a day, 7 days a week and requires the member's date of birth, and State ID or SSN. Eligibility information is updated daily, except for weekends and state holidays.
Providers may verify eligibility through one of the following means:

HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response

The HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction is designed to allow providers to obtain member eligibility information using electronic data transfer. The HIPAA 270/271 eligibility verification system provides:

- Date span verification.
- Eligibility status
- Ability to print eligibility responses

Specific directions on how to submit a 270 eligibility inquiry and what to expect in the 271 eligibility response may be found in the 270/271 Companion Guide located in the Provider Services Specifications section.

Health First Colorado Provider Portal:

Providers may visit the Department's website for recorded webinars @ https://www.colorado.gov/pacific/hcpf/interchange-resources

To find training on the Health First Colorado Provider Portal @ https://www.colorado.gov/hcpf/provider-training

Health First Colorado Eligibility Response System (CMERS)/ Interactive Voice Response System (IVRS)

Child Health Plan Plus Eligibility Response System (CMERS)/Interactive Voice Response System (IVRS) is an automated voice response system that furnishes dental providers with:

- Unlimited Child Health Plan Plus eligibility verification inquiries
- Eligibility for service by type
- Eligibility date spans
- Co-payment status
- Third party liability
- Managed care enrollment

To access the **CMERS/IVRS**, providers may call toll free: **844-801-8478**, or go to the Health First CO website @ https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider/Home/tabid/135/Default.aspx

Delayed/Retroactive Eligibility

In some instances, a member's eligibility is determined to commence prior to the date the member submitted an application – this is delayed/retroactive eligibility. Charges for services are the member's responsibility until eligibility is established. (Example: A member is "pending" Child Health Plan Plus eligibility. The member receives services prior to the determination of eligibility. The member is responsible for payment for services until the eligibility determination is final. If the client is subsequently determined to have been eligible on the date of service, the provider may submit claims for the date of service to Child Health Plan Plus/DentaQuest). Claims are denied if the member's eligibility status is not available through eligibility verification methods. See Timely Filing in section 8.10 for more information.

3.00 Prenatal Benefit Program

On October 1, 2019, dental services became available for CHP+ prenatal women. They benefit from the same services provided for current CHP+ children except for orthodontics (braces). These benefits include:

- Diagnostic services (exams and x-rays)
- Preventive (fluoride, sealants, and cleanings)
- Basic restorative services (fillings)
- Endodontics (root canals)
- Emergency dental services

The annual maximum allowable benefit is $1,000 per calendar year (Janurary 1st through December 31st) while the member is eligible and enrolled. Members can contact DentaQuest at 1-888-307-6561, TTY 711, or email through the Member Access Portal at memberaccess.dentaquest.com.

4.00 Dental Home Program

DentaQuest will establish a dental home program for CHP+ members, whereby each member will be assigned to a general or pediatric dentist to oversee their dental needs. DentaQuest's dental home program honors the American Academy of Pediatric Dentistry's (AAPD) definition of a dental home as "the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate." When assigning members to a dental home, we align them with a high performing provider group that is closest to the member and within the state required mileage limits. It's important to keep in mind that if a member has history with a provider, we assign them to their historical provider group to foster the already established relationship and continuity of care. We also keep family members together wherever possible.

If you would like a member to be assigned to your office, please have the member or guardian call the Member Service Line at 888-307-6561. They will also be able to set a dental home assignment via the Member Portal.

Claims will not be denied if a member is not assigned to your location.

5.00 Broken Appointment Program

Missed dental appointments foster deferred or avoided care for members that can lead to long-term negative health impacts and higher costs to the system.

Best Practices to Prevent Broken Appointments

- Create and distribute a strong, no tolerance policy for all patients (not just CHP+ members).
- Create a contract committing to the broken appointment policy for all patients to sign.
- Provide reminder messages to patients 48 hours prior to appointments.
- Scheduling appointments no further out than 30-45 days.
- Having patients with emergency situations call back to schedule their follow-up appointment a few

days after the emergency visit.

6.00 Authorization For Treatment

6.01 Authorization for Treatment

Authorization is a utilization tool that requires Participating Providers to submit “documentation” associated with certain dental services for a member. Participating Providers will not be paid if this “documentation” is not provided to DentaQuest. Participating Providers must hold the member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (please reference Clinical Criteria section). Please review these criteria as well as the Covered Services Benefit Tables, Appendix B, Exhibit A, to understand the decision-making process used to determine payment for services rendered.

Services that require prior authorization are clearly designated within the Covered Services Benefit Tables, found in Appendix B, Exhibit A, of this document. Please reference these tables for a specific list of codes requiring prior authorization.

A. Authorization and documentation submitted before treatment begins (Non-emergency), Prior Authorization Request (PAR)

Services that require prior authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the Prior Authorization Request (PAR). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. In these instances, if the PAR is denied the treating Provider will be financially responsible and may not balance bill the member, the Plan and/or DentaQuest. When a PAR is approved, the provider determination letter will include the authorization number and clearly state when the PAR expires. This is usually 180 days, and 1080 days for Orthodontia services. Services must be rendered while the PAR is active, and the member is eligible. An approved PAR is not a guarantee of payment. If services are rendered after a PAR expires, payment will be denied. It is the Providers responsibility to make sure the PAR is in effect on the DOS. Providers may use the Provider Portal to look up the active span of a PAR.

If a Provider wishes to extend the expiration date of a PAR (with the exception of Ortho PAR’s which do not qualify for an extension), please request a PAR extension before the current PAR expires. Call Provider Customer Service at 855.225.1731 to make your request or use the Provider Portal. You will receive a letter by mail or fax with the approval or denial of the extension, along with the new expiration date. The length of time a provider may extend a PAR varies depending on the specific service.

Some other reasons why claims may be denied even with an approved PAR are:

- member eligibility changes,
- program coverage differences between Medicaid and CHP+,
- treatment changes from what was approved in the PAR, or
- member reaches annual maximum benefit.

This list is not inclusive of all instances for non-payment with an approved PAR. Providers with specific questions on payment with an approved PAR should contact their network manager.
Submission of PARs should include:

1. Radiographs, narrative, or other information where requested (please reference Covered Services Benefit Tables, Appendix B, Exhibit A, for specifics by code)

2. CDT codes on the Current ADA claim form

   Your submission should be sent on a Current ADA claim form. The Covered Services Benefit Tables, Appendix B, Exhibit A contain a column marked Prior Authorization Required and Pre-Payment Review. A "Yes" in this column indicates that the service listed requires prior authorization to be considered for reimbursement.

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

B. Submitting Authorization Requests and X-Rays:

- Electronic submission using the Provider Web Portal

- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.

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

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

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

Acceptable methods of mounted radiographs are:

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

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

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.

- Cut out radiographs placed in a coin envelope.

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

All radiographs should include member's name, identification number, and date of x-ray, marker to designate the L or R side, and office name to ensure proper handling.

C. Authorization and documentation submitted with claim, after non-emergency services are rendered - **Pre-Payment Review (PPR)**

In an effort to allow greater freedom for Participating Providers to appropriately treat a member in a timely manner, DentaQuest performs pre-payment review (PPR) on many types of covered services in lieu of requiring a Prior Authorization Request (PAR). The Department determines which covered services can utilize PPR so that Participating Providers can treat the member and submit the required documentation with the claim for reimbursement after the services have been rendered. DentaQuest will complete medical necessity review using the same clinical criteria as PARs. By utilizing the PPR process, the Department and DentaQuest aim to eliminate any delay in treating the member, as well as eliminating the need for a two-step process for payment. PPR is not available on all covered services. Participating Providers must consult the Covered Services Benefit Tables in Appendix B, Exhibits A to determine which services are available for PPR and those services which a PAR is required before services are rendered. The required documentation necessary to support the medical necessity review under the PPR process can also be found in the benefit tables in Exhibits A, B, and C. When submitting for PPR, the same required documentation must be attached as if submitting for PAR.

6.02 Electronic Attachments

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, periodontics charts, intraoral pictures, narratives and Explanations of Benefits (EOBs).

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.
For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at: 800.782.5150.

7.00 Participating Hospitals

Participating Providers are required to administer outpatient services at the Department's participating hospitals and ambulatory surgery centers. The Participating Provider should submit planned services to DentaQuest via the prior authorization request (PAR) process to obtain medical necessity authorization for use of a hospital facility or Ambulatory Surgical Center (ASC). Services cannot be rendered until after the PAR is approved. Please be aware that hospital and ASC costs are not reimbursable. PARs are usually issued for 180-day period. Please reference the Provider Determination Letter for specific dates.

The facility's name and address should be included in Box 35 of the PAR submission form. Upon receipt of approval from DentaQuest, the Provider should contact the hospital, ASC, etc. at which he/she has the appropriate staff privileges for facility authorization. For more information, please reference Section 15.13, Clinical Criteria for PAR of Hospital or Outpatient Facility.

Participating Hospitals may change. Please visit the Department's website for a current listing https://www.colorado.gov/hcpf/find-doctor and select hospital under the "Find Providers By Type" drop down.

8.00 Claim Submission Procedures (Claim Filing Options)

DentaQuest receives dental claims in 4 possible formats. These formats include:

- Electronic claims via DentaQuest's website (www.dentaquest.com)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims via US Postal Service or Fax 262.834.3589

8.01 Submitting Prior Authorization or Claims with X-Rays Portal (PWP)

- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)
- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

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

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

All radiographs should include member's name, identification number, and date of x-ray, marker to designate the L or R side, and office name to ensure proper handling.

8.02 Electronic Claim Submission Utilizing DentaQuest's Provider Web Portal

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

To submit claims via the portal, 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 Provider Service Department at 855.225.1731. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry ". The Provider 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 portal, please contact our Systems Operations at 1.800.417.7140 or via e-mail at: EDITeam@greatdentalplans.com

8.03 Electronic Authorization Submission Utilizing DentaQuest's Provider Web Portal

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our Provider Web Portal (PWP). Submitting Pre-Authorizations via the portal is very quick and easy. It is especially easy if you have already accessed the site to check a member's eligibility prior to providing the service.

To submit prior authorization requests (PARs) via the portal, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Service Department at 855.225.1731 Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry ".

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

8.04 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1.888.255.7293), Tesia (1.800.724.7240), EDI Health Group (1.800.576.6412), Secure EDI (1.877.466.9656), and Mercury Data Exchange (1.866.633.1090) for claim submissions to DentaQuest.

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

8.05 HIPPA 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.

8.06 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website

https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.

- All Providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPIs. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it follows the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.
- Please make sure when you are submitting claims that the appropriate NPI is listed in the required billing and treating NPI sections.

8.07 Paper Claims Submission

- Claims must be submitted on a current ADA claim form
- 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 member cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable Provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the Provider signature is used for identification, the Provider's name cannot be clearly identified. Please include either a typed Provider (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 current 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 Provider who provided the treatment. For example, on a standard current ADA Dental Claim Form, the treating Provider'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 manual 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 – CO
P.O. BOX 2906
Milwaukee, WI 53201-2906

Or Fax to: 262.834.3589

8.08 Coordination of Benefits

Colorado CHP+ is always the payer of last resort. When members have other insurance, any other carrier's Explanation of Benefits (EOB) must be submitted with the claim. The primary carrier's EOB must

include the member's information, name of the primary insurance carrier, submitted codes, and denial reason, if applicable. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate Coordination of Benefits (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**.**

8.09 Receipts 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 Provider identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an Explanation of Benefit (EOB) report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

8.10 Payment for Non-Covered Services and Billing Members

Participating Providers agree to accept the DentaQuest payment as payment in full for benefit services with exception to Orthodontics. Colorado law prohibits Providers from billing Child Health Plan Plus members or the estates of deceased members for benefit services.

Participating Providers shall hold members, DentaQuest and the Department harmless for the payment of non-Covered Services except as provided in this paragraph.

Member billing is prohibited for the following:

- Colorado Child Health Plan Plus considers the appropriate Personal Protective Equipment (PPE) an operating expense and will not reimburse for its use, nor can the member be billed for its use. D1999 is a non-covered code and is not considered as reportable for Personal Protective Equipment by Colorado Child Health Plan Plus. Providers are also prohibited from charging members for PPE costs through copayments, visit surcharges, lab fees or any other means.
- A covered service is defined as:
    - A covered benefit as defined in the Covered Services Benefit Tables in the DentaQuest Child Health Plan Plus Office Reference Manual (ORM) Appendix B, Exhibit A.
- Participating Providers may not assert a lien on any money, settlement, recovery or judgment paid to the member or to the member's estate as the result of personal injury lawsuit.
- Constraints against billing members for benefit services apply whether or not DentaQuest makes or has made payment and whether or not the Provider participates in the DentaQuest Provider Network.
- Participating Providers may not bill DentaQuest for missed appointments, telephone calls, completion of claim forms, medication refill approvals or Personal Protective Equipment (PPE).
- Members may not be billed if the failure to obtain claim payment from DentaQuest is caused by the Participating Provider's failure to comply with the DentaQuest program billing procedures.
- Collection agencies cannot submit DentaQuest claims for payment and cannot collect payment from a member.

Participating Providers may bill a member for Non-Covered Services. A non-covered service is:

- Any procedure code that is not listed as a covered benefit in the ORM
  or
- Any procedure code listed as a covered benefit in the ORM that has been denied by

DentaQuest through a prior authorization request (PAR) or a claim.
or

- Services rendered beyond the frequency limits listed in the ORM
or
- Non-medically necessary services rendered beyond the members $1000 annual maximum

The Provider must obtain an explicit written acknowledgment of financial responsibility that includes the service the member is responsible for, the amounts owed, and positive confirmation that the services are confirmed to be not covered from the member **prior** to rendering such services. The Participating Provider may only bill the member if a non-disclosure agreement is completed and signed by the member. The providers non-discolsure agreement must include the date of service, dental services being rendered, and acknowledgement of the member being liable for payments of non-covered services

- If the service is not a covered benefit listed on the Covered Services Benefit Table (Appendix B, Exhibit A), members may be billed for the service. Participating providers may bill their UCR, however we strongly encourage providers to stick to the recommended fees in the Non-Covered Benefit Fee Schedule.
- If the service **is** a covered benefit listed on the Covered Services Benefit Table (Appendix B, Exhibit A) that has denied, members may be billed for the service. Participating providers are only allowed to bill patients the fee listed on the Child Health Plan Plus fee schedule.
- If the service is for a Child Health Plan Plus member that exceeds the $1,000 annual limit and is not found to be medically necessary, members may be billed for the service. Participating providers are only allowed to bill patients the fee listed on the Child Health Plan Plus fee schedule.
- Participating providers are not allowed to charge over the agreed upon Child Health Plan Plus fees for any code listed on the Covered Services Benefit Table (Appendix B, Exhibit A).
- Some members are responsible for a CHP+ co-payment. By federal law, Participating Providers may not refuse services if the member cannot pay a co-payment when services are rendered. Members may be billed for unpaid co-payments. Participating Providers may apply standard collection policies if the member fails to satisfy co-payment obligations.
- Members enrolled in DentaQuest must follow the DentaQuest rules. Members who insist upon obtaining care outside of the contracted network will be charged for non-covered services.

When providers may charge members			
	Fee charged	***Document title***	***Notes/requirements***
Covered service, which is denied	CHP+ fee schedule amount	"CHP+ fee schedule" on DQ portal and website	Member must sign non-disclosure agreement before services are rendered
Non-covered service	It is recommended to charge the CHP+ non-covered fee schedule amount, but UCR may also be charged.	"CHP+ non-covered code fee schedule" on DQ portal and website	Member must sign non-disclosure agreement before services are rendered

Third Party Co-Payments

Members eligible for dental services may not be billed for third party co-pays, unpaid co-payments or deductibles when seen by a Participating Provider. Dental Services are third party co-pay exempt. For additional information visit Health First Colorado's General Provider Information Manual.

8.11 Timely Filing

Original Timely Filing (365 days from DOS)

Timely filing for Child Health Plan Plus claim submission is **365 days from the date of service or from the date of the member's primary dental insurance EOB**. A claim is considered to be filed when DentaQuest documents the **receipt** of the claim. **We encourage providers to submit claims soon after services are rendered as claims are subject to benefit limitations and payment based on the date received, not the date of service.**

- With few exceptions, electronic claims can be submitted 24 hours a day, 7 days a week. When an electronic claim is submitted, the electronic system automatically notifies the submitting party either that the system has accepted the claim for processing, or that the system has rejected the claim due to some deficiency. These electronic acceptance and rejection messages include the transaction date, which is the date DentaQuest documents receipt of the claim.
- DentaQuest documents receipt of a paper claim by assigning a Claim Number. This is captured in the "Received Data" field, viewable on the Provider Web Portal (PWP).
- Paper claim mailing address:
  DentaQuest - CO
  PO Box 2906
  Milwaukee, WI 53201-2906
- State holidays, weekends, and dates of business closure do not extend the timely filing period.
- Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The Participating Provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the Participating Provider because of missing information and rejected electronic claims, all claims filed with DentaQuest appear on the Explanation of Benefits (EOB) as paid or denied within 30 days of receipt. If claim information does not appear on the EOB within 30 days of an electronic transmission or paper claim mailing, the Participating Provider is responsible for contacting DentaQuest to determine the status of the claim and resubmitting the claim if necessary.

Timely Filing Extensions for Circumstances Beyond the Provider's Control

Timely Filing Exceptions are granted only when the Participating Provider is able to document that appropriate action to meet filing requirements was taken and that the Participating Provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled:

- Delayed processing by third party resources
- Delayed/retroactive member eligibility
- Delayed notification of eligibility
- Other circumstances beyond the Provider's control

Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not considered extenuating

circumstances beyond the Participating Provider's control. Timely filing exceptions will not be considered if the provider has not been actively trying to seek resolution of a claim within the original timely filing period.

Making false statements about timely filing compliance constitutes false claims and may subject the individual who prepares the claim and the Participating Provider to fines and imprisonment under state and/or federal law.

For extension of timely filing due to corrections of errors on claims, see section 8.11 Corrected Claims.

Delayed/Retroactive Member Eligibility
If the timely filing period expires because eligibility determination is delayed or back-dated, DentaQuest is authorized to consider the claim to be filed timely if it is received within 365 days of the date that the member's eligibility is approved. Providers will need to submit an initial claim, which will deny for timely filing. Providers must then submit the claim for appeal, via the DentaQuest Appeal process. Each claim must have an attached Department-authorized form or letter from the County Department of Human/Social Services that verifies the delayed eligibility determination or backdated eligibility, and meet the following requirements:

- The document is identifiable as a county document (e.g., correspondence printed on county letterhead or an imprinted or typeset form).
- The Appeal narrative states specifically that eligibility was delayed and/or backdated and indicates the dates of eligibility.
- The Appeal states the date that such action was entered into the State's eligibility system.

8.12 Corrected Claims

Providers may make corrections to incorrectly submitted claims during the timely filing period. For a claim to be treated as a corrected claim, it must be submitted within 365 days from the date of service, or within 60 days from the last adverse action/denial. (Please see section 8.12 DentaQuest Provider Appeals for an explanation of adverse actions.)

- The corrected claim must clearly state the word "Corrected" in box 35 along with the claim number of the claim you are correcting.

- The corrected claim must contain clear and accurate corrections to the erroneous information. (A resubmission of identical claims data is not considered a corrected claim. The corrected claim must include additional or different information.)

- If a claim is resubmitted for correction more than once, each must be submitted within 60 days of the adverse action on the previous submission.

DentaQuest will research the resubmission and adjudicate the corrected claim according to the resubmitted information. Once adjudicated, the corrected claim will appear on the Provider's Explanation of Benefits (EOB) with a corresponding Processing Policy outlining the reason for payment or denial.

Providers must maintain proof of claim submission history in their files for six years.

8.13 DentaQuest Provider Appeals

A Provider who disagrees with DentaQuest's decision on a Prior Authorization Request or with a claim determination may submit a written request for Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This request *and* additional supporting information must be sent to DentaQuest within 60 days from the date of the last adverse benefit determination. NOTE: Overpayment recoupments listed on your EOBs will not be made for 60 days to allow for an appeal.

A Provider may request an appeal for the following adverse actions:

- A dispute regarding the payment amount
- Provider Out-Of-Network for claim
- Provider Out-Of-Network for PAR or PPR
- Timely filing for claim

A Provider may request an appeal on behalf of the member with their consent for the following adverse actions:

- Eligibility for PAR or PPR
- Eligibility for Claim
- Medical necessity for a PAR or PPR
- Medical necessity for a claim

Members or their representative may appeal PAR, PPR, or claim denials.

Prior to requesting an Appeal, a provider may request a peer-to-peer meeting for any medical necessity denial. See section 10.00 Grievances, and Appeals.

A Provider may submit a request for an Appeal by mail or through the Provider Portal. The mailing address is:

DQ Complaints and Grievances
P.O. BOX 2906
Milwaukee, WI 53201-2906

To submit via the Provider Portal, please follow these steps:

- Log into the Portal (provideraccess.dentaquest.com)
- Click on "Claims/Claims Search" or " Authorization & Estimate/ Authorization & Estimate Search"
- Search for claim/authorization in question (must be listed as **FINALIZED**)
- Click on listed claim/authorization number
- Click "Appeal" Button

Write/attach the new and/or corrected information required for the dental team to consider redetermination of the claim

Provider Appeal Definition

CMS requires the Colorado Child Health Plan Plus program to use different appeal requirements and timeframes depending on whether the appeal is considered a provider appeal (payment dispute) or a member appeal (provider appealing on behalf of the member). Please use the table below for assistance with these definitions.

Appeal Reason	Provider appeal (payment dispute)	Provider appeal on behalf of a member
Eligibility for PAR or PPR		X
Eligibility for Claim		X
Medical necessity of a PAR or PPR		X
Medical necessity of a claim		X
Provider OON for PAR or PPR	X	
Provider OON on claim	X	
Timely filing for claim	X	
Dispute regarding payment	X	

Member Consent Requirements

If DentaQuest denies a claim or pre-authorization (PAR) or Prior-Authorization (PPR) that falls under the provider appealing on behalf of the member column above, Colorado requires practicing CHP+ dental providers to include member written consent when submitting the appeal. Please include a copy of the members written consent when submitting your appeal via the DentaQuest portal or mail. Provider appeals filed on behalf of the member that do not include the members written consent will be rejected.

Written Member Consent

The required member written consent must be specific to the date of service and codes being appealed to DentaQuest. We have provided a written consent form example on page 77 but allow providers to create and use their own.

DentaQuest Provider Appeal Rights

Providers may appeal a denial by requesting a hearing with a state administrative law judge. A request for a State Fair Hearing my only occur after receiving an appeal resolution notice that DentaQuest is upholding the adverse benefit determination. For appeals filed on behalf of a member, for eligibility or medical necessity denials, the provider must have the member's written permission before filing, and appeals must be received by the court within 120 days of the adverse appeal resolution letter.

To file an appeal, submit a written request which includes:

- Provider name, address, phone number and Health First Colorado provider number
- A statement explaining the reason for the appeal
- Attach the front page of the notice you are appealing
- It the appeal is on behalf of a member, attach the member's written permission

Submit the written request by mail or fax to:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203
FAX: 303.866.5909

The Office of Administrative Courts will contact you by mail with the date, time and place for your hearing with the Administrative Law Judge. You may request that the hearing be conducted by phone.

8.14 Direct Deposit

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

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

- Complete and sign the Direct Deposit Authorization Form that can be found on the Provider Web Portal (www.dentaquest.com).
- 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 Mail
  DentaQuest - CO
  P.O. BOX 2906
  Milwaukee, WI 53201-2906
  Attn: PEC Department

  Via Fax – 262.241.4077

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Participating Providers should allow up to 6 weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Participating Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Participating 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 Participating Providers do not properly notify DentaQuest in writing of any banking changes.

Participating Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Participating 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 under "New Portal" using your password and ID
4. Once logged in, select "Explanation of Benefits"
5. The Explanation of Benefits will display on the screen.

9.00 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 Participating Providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its Participating Provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about members according to applicable state and federal laws and regulations. All material and information, in particular information relating to members or
- potential members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (e.g., American Dental Association Current Dental Terminology, as recognized by the ADA. Effective the date of this manual, DentaQuest will require Participating Providers to submit all claims with the current ADA/CDT codes listed in this manual. In addition, all paper claims must be submitted on the current ADA claim form. **Dental Providers cannot bill Child Health Plan Plus for Current Procedural Terminology (CPT) medical and surgical codes.**

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 855.398.8411 or via e-mail at: denelig.benefits@dentaquest.com.

9.01 HIPAA Companion Guide

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

10.00 Grievances and Appeals

DentaQuest adheres to State, Federal, and Plan requirements related to processing grievances and appeals. Note: Overpayment recoupments listed on your EOBs will not be made for 60 days to allow for an appeal. Unless otherwise required by the Department, DentaQuest processes such grievances and appeals consistent with the following:

Grievances

Grievance means a written or oral expression of dissatisfaction about any matter other than an adverse action. If a verbal or written grievance is received from a Provider or member, the Complaints and Grievances Representative is responsible for documenting the issue(s). DentaQuest will treat oral appeals in the same manner as appeals received in writing. DentaQuest will not require that oral requests for an appeal be followed with a written request. Written consent is required to submit a grievance on behalf of a member. DentaQuest will assist a member in filing the grievance if requested. The Representative investigates the issue(s), compiles the findings, requests patient records (if applicable), and sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals
are notified of the results (i.e. Plan, member, and Provider as applicable).

Grievance Time Frames:

• DentaQuest will allow a Member to file a grievance either orally or in writing at any time and shall acknowledge receiving the grievance with written acknowledgement within two (2) business days of receipt.
• DentaQuest will make a decision regarding the grievance and provide notice to the member of its decision within fifteen (15) business days of when the Member files the
grievance.
• DentaQuest may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if a member requests; or if DentaQuest shows (to the satisfaction of the Department, upon its request) that there is a need for additional information and that the delay is in the member's best interest.

- Should DentaQuest extends the timeline for the grievance not at the request of the member, the DentaQuest will:
  - Make reasonable efforts to give the member prompt oral notice of the delay
  - Give the member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

Pre Authorization Clinical Appeal

The Pre Authorization Clinical Appeal process is a second review by a non-Colorado (i.e. “other market”) DentaQuest Dental Director (who was not involved in the original determination) that is used for provider disagreements with clinical denials. These requests must be submitted by the Provider within sixty (60) calendar days of the denial decision, and which then goes through the following process:

- Review is completed by a Dental Director of the same profession and specialty as the ordering dental Provider.
- Review will include all information submitted and any additional information the dental Provider wishes to submit.
- Dental Director may overturn or uphold the original denial decision.

Peer-to-Peer Process to Discuss Denial Determination

Participating Providers must request a peer-to-peer call for any clinical denial within five (5) calendar days from a denial decision. This request must occur prior to the member receiving the NABD, otherwise the appeal process must be conducted with members being parties to the appeal. The peer-to-peer call will be a verbal discussion with a DentaQuest Dental Director (who was not involved in the original determination) to discuss denial determination. Any additional clinical information to be discussed in the peer-to-peer call should be submitted within the first five (5) calendar days from a denial decision. The peer-to-peer process does not have to be utilized prior to requesting an Appeal. You are only able to request a peer-to-peer for medically necessary denials.

Claim Appeal
The claim appeal process is used for provider disagreements with claim denials. This process may also be utilized for medically necessary procedural changes that may occur mid treatment and were not included on the original PAR or treatment plan. Participating Providers must submit all appeals of denied claims within 60 days from the date of disposition of the Explanation of Benefits (EOB) on which that claim appeared. Claim Appeals can be submitted through the DentaQuest Provider Portal or can be mailed to:

DentaQuest – CO Child Health Plan Plus Dental Services
P.O. BOX 2906
Milwaukee, WI 53201-2906

DentaQuest will respond and resolve the appeal within ten (10) business days following the receipt of the appeal (not from when documents are received) unless an extension is request in writing that meets the content requirements.

Member Appeals Rights
Members have the right to appeal any adverse determination made on a claim or pre authorization, whether in whole or in part. An appeal request must be submitted within 60 days of the date of the original Explanation of Benefits (EOB). The appeal can be verbal or written. Expedited appeals can be made through customer relatations at 1-888-307-6561, TTY 711 (toll-free). If additional information is needed to complete a review of an expedited appeal, DentaQuest shall immediately notify the member and the members provider by telephone or facsimile to identify and request the necessary information, followed by a written notification.

All written appeals should be sent to:
DentaQuest Appeals
PO Box 2906
Milwaukee, WI 53201

The members guardian, dentist, or someone they want to represent them can call customer relations at 1-888-307-6561, TTY 711 (toll-free) or write to DentaQuest at the address listed above to request a DentaQuest appeal. In addition, DentaQuest customer relations is available to assist with the appeal filing process. If the members DentaQuest appeal has been upheld, they have the right to a second-level appeal through the Administrative Law Judge.

Members have the right to request a member (i.e., “client”) appeal hearing directly with an Administrative Law Judge with the State of Colorado. A State Fair Hearing means that a State Administrative Law Judge (ALJ) will review DentaQuest’s decision or action. Members may request a State Fair Hearing only after receiving an appeal resolution notice that DentaQuest is upholding the adverse benefit determination.

The member may represent them self, or have a Designated Client Representative (DCR) represent them. A DCR can be their dentist, a lawyer, a relative, a friend or other spokesperson to assist them as their authorized representative. The Administrative Law Judge (ALJ) will review DentaQuest's decision or action. The final agency decision will be rendered. This decision is final. Please have the member send their written request to the address below.

How to submit an ALJ Appeal:

1. You must ask for a hearing in writing. This is called a **State Fair Hearing**.
2. Your State Fair Heating request must include:
    a. Your name, address, phone number and State ID;
    b. Why you want a hearing; and
    c. A copy of the front page of the notice of action you are appealing.
3. You may ask for a telephone hearing rather than appear in person.
4. Mail or fax your letter of appeals to:

    OFFICE OF ADMINISTRATIVE COURTS
    1525 SHERMAN STREET, 4TH Floor
    DENVER, CO 80203
    Phone: 303.866.8626 Fax: 303.866.5909

Your State Fair Hearing request must be received by the Office of Administrative Courts no later than one hundred twenty (120) calendar days from the date of the notice of appeal resolution. The date of the notice of action is located on the front of this notice.
The Office of Administrative Courts will contact you by mail with the date, time and place for your hearing with the Administrative Law Judge.

Expedited Member Hearings
If you or the member think waiting for a hearing will seriously risk the members life or health, they can ask for an expedited (faster) hearing.
To Request an expedited hearing:

1. Write the Letter of Appeal using the instructions above for how to appeal.
2. Include in your Letter of Appeal:
    a. Your request for an expedited hearing.
    b. Explain how and why your life, health, or ability to regain, attain or maintain maximum function would be at serious risk if you do not have an expedited (faster) appeal.
    c. Provide additional information to help explain why you need an expedited appeal.

The member will be contacted by phone to set up a hearing date and time if their request for an expedited hearing is approved. If their expedited hearing is denied, they will be notified in writing. The member will still be able to have a non-expedited hearing.

11.00Utilization Review Program

11.01 Introduction

Reimbursement to Providers 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 Participating Provider reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medicaid Dental Programs, the State Legislature annually appropriates or "budgets" the amount of

dollars available for reimbursement to the Providers as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the Participating Provider. These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to those Participating Providers of crucial importance.

11.02 Community Practice Patterns

DentaQuest has developed a philosophy of Utilization Review (UR) that recognizes the fact that there exists, as in all healthcare services, a relationship between the Participating Provider’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 Providers and their peers. With this in mind, DentaQuest’s Utilization Review Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local Providers and their peers.

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

11.03 Evaluation

DentaQuest’s Utilization Review Programs evaluate claims submissions in such areas as:

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

11.04 Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these “budgeted” Child Health Plan Plus dollars to Participating Providers, DentaQuest’s Utilization Review Programs will help identify those Participating Providers whose patterns show significant deviation from the normal practice patterns of the community of their peer Participating Providers (typically less than 5% of all Participating Providers). When presented with such information, Participating Providers will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

11.05 Fraud and Abuse

DentaQuest is committed to detecting, reporting and preventing potential fraud, waste, and abuse. Fraud, waste, and abuse are defined as:
“Fraud” includes making a false statement or misrepresenting information to get something that benefits oneself or someone else. There are many forms of fraud. It includes any act that constitutes fraud under federal or state law.

Examples of actions by Child Health Plan Plus Providers which may be fraud include:

- Billing Child Health Plan Plus/DentaQuest for office visits, dental or medical procedures, drugs, or supplies that are not provided to a member.
- Billing for the same services twice.

Examples of actions by Child Health Plan Plus members which may be fraud include:

- Providing false information on applications in order to receive benefits.
- Loaning your Child Health Plan Plus/DentaQuest ID card to others.
- Selling or buying a Child Health Plan Plus/DentaQuest card.
- Giving or selling medication or medical/dental supplies to someone else.
- Forging prescriptions.

”Waste” includes over-utilizing Child Health Plan Plus services, supplies or equipment, or causing unnecessary costs through carelessness or inefficiency.

“Abuse*****” includes activities that result in unnecessary costs to the Colorado Medical Assistance Program.

- If you suspect fraud, waste or abuse, please report it to DentaQuest immediately.
- Call DentaQuest toll free at 800.237.9139
- Call DentaQuest Anonymous Hotline at 866.737.3559.
- Send a fax to: 262.241.7366
- Mail information to:

  DentaQuest
  P.O. BOX 2906
  Milwaukee, WI 53201-2906
  Attn.: Utilization Review Department

***Please note**: Report physical or emotional abuse to the police.

Statement of Penalties for Members

If a member makes a willfully false statement or representation or use other fraudulent methods to obtain public assistance or medical assistance a member is not entitled to, that member could be prosecuted for theft under state and/or federal law. If a member is convicted by a court for fraudulently obtaining such assistance, that member could be subject to a fine and/or imprisonment for theft.

More information on Fraud, Waste and Abuse can be found on the Department’s website https://www.colorado.gov/pacific/hcpf/fraud-waste-and-abuse

12.00 Quality Improvement

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

- Member satisfaction surveys
- Provider satisfaction surveys
- Random Chart Audits
- Complaint Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Initial Site Reviews and Dental Record Reviews

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

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Service Department at 855.225.1731 or via e-mail at: denelig.benefits@dentaquest.com

13.00 Provider Credentialing and Enrollment

In order to be reimbursed for treating Child Health Plan Plus members you will first need to enroll with the Department in order to get a Provider ID. Enrolled providers must have and maintain licensure and certification required by Child Health Plan Plus regulations. Providers seeking to enroll can find information regarding enrollment on the Department's website https://www.colorado.gov/hcpf/provider-enrollment. After completing enrollment with the Department, you will need to credential with DentaQuest. Please find DentaQuests credentialing application on our website https://dentaquest.com/dentists. To start the application, click "Start a New Online Credentialing Application".

14.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:
    A. Registration data including a complete health history.
    B. Medical alert predominantly displayed inside chart jacket.
    C. Initial examination data.
    D. Radiographs.
    E. Periodontal and Occlusal status.
    F. Treatment plan/Alternative treatment plan.
    G. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    H. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
    A. Health history.
    B. Medical alert.
    C. Examination/Recall data.
    D. Periodontal status.
    E. Treatment plan.
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

B. Content

The patient record must contain the following:

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

A. Patient's first and last name.
B. Date of birth.
C. Gender.
D. Address.
E. Telephone number.
F. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:
   A. Current medical treatment.
   B. Significant past illnesses.
   C. Current medications.
   D. Drug allergies.
   E. Hematologic disorders.
   F. Cardiovascular disorders.
   G. Respiratory disorders.
   H. Endocrine disorders.
   I. Communicable diseases.
   J. Neurologic disorders.
   K. Signature and date by patient.
   L. Signature and date by reviewing Provider.
   M. History of alcohol and/or tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
   A. Significant changes in health status.
   B. Current medical treatment.
   C. Current medications.
   D. Dental problems/concerns.
   E. Signature and date by reviewing Provider.

4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
   A. Health problems which contraindicate certain types of dental treatment.
   B. Health problems that require precautions or pre-medication prior to dental treatment.
   C. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   D. Drug sensitivities.
   E. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items
   A. Blood pressure. (Recommended)
   B. Head/neck examination.
   C. Soft tissue examination.
   D. Periodontal assessment.
   E. Occlusal classification.
   F. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
   A. Blood pressure. (Recommended)
   B. Head/neck examination.
   C. Soft tissue examination.

D. Periodontal assessment.
E. Dentition charting.

F. Radiographs which are:
G. Identified by patient name.
H. Dated.
I. Designated by patient's left and right side.
J. Mounted (if intraoral films).

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

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

9. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
   A. Periodontal pocket depth.
   B. Furcation involvement.
   C. Mobility.
   D. Recession.
   E. Adequacy of attached gingiva.
   F. Missing teeth.

10. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
    A. Gingival status.
    B. Amount of plaque.
    C. Amount of calculus.
    D. Education provided to the patient.
    E. Patient receptiveness/compliance.
    F. Recall interval.
    G. Date.

11. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
    A. Provider to whom consultation is directed.
    B. Information/services requested.
    C. Consultant's response.

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

13. Adequate documentation of the specialty care performed by another Provider that includes:

A. Patient examination.
B. Treatment plan.
C. Treatment status.

14. Tobacco cessation education should be noted in the record. Support is available for Child Health Plan Plus members. Refer members 18 years and older with a desire to quit to their primary care provider to get a prescription for tobacco cessation products. Child Health Plan Plus pays for any federal Food and Drug Administration (FDA) approved medications or products for two 90-day sessions each year to assist a member in quitting. Refer members 15 years and older to the Quitline for free telephone-based tobacco treatment (coaching), online, email, and text support at 1-800-QUIT-NOW or https://www.coquitline.org/en-US/. For more information on how to discuss tobacco use with members, visit https://www.tobaccofreeco.org/.

C. Compliance

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

15.00 Patient Recall System Requirements

A. Recall System Requirement

Each participating Child Health Plan Plus/DentaQuest dental 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 enrollee that has sought dental treatment.
Dental offices indicate that Child Health Plan Plus patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

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

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

B. Office Compliance Verification Procedures

In conjunction with its office claim audits described in Section 8.10 DentaQuest will measure compliance with the requirement to maintain a patient recall system.

Child Health Plan Plus/DentaQuest Participating Providers are expected to meet minimum standards with regards to appointment availability.

- Urgent care must be available within 48 hours
- Emergency care must be available within 24 hours
- Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

16.00Radiology Requirements

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health (i.e., "The Panel"). These guidelines were developed in conjunction with the Food and Drug Administration Revised 2004, American Dental Association, Council on Dental Benefit Program, Council on Dental Practice, Council of Scientific Affairs.

A. Radiographic Examination of the New Patient

Child – Primary Dentition: Prior to eruption of first permanent molar.
The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts, individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.

Child – Transitional Dentition: After eruption of first permanent molar
The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

Adolescent – Permanent Dentition Prior to the Eruption of the Third Molars:
The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings and panoramic exam for a new adolescent patient. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.

Adult – Dentulous: or Partially Edentulous
The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings with panoramic exam for a new dentulous adult patient. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.

Adult – Edentulous:
The Panel recommends individualized radiographic exam, based on clinical signs and symptoms.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or at increased risk for caries

a. Child – Primary and Transitional Dentition:
The Panel recommends that posterior bitewings be performed at a 6-12-month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition if proximal surfaces cannot be examined visually or with a probe.

b. Adolescent with Permanent Dentition:
The Panel recommends that posterior bitewings be performed at a 6-12-month interval for

adolescents with clinical caries or who are at increased risk for the development of caries if proximal surfaces cannot be examined visually or with a probe.

c. Adult – Dentulous:
The Panel recommends that posterior bitewings be performed at a 6-18-month interval for adults with clinical caries or who are at increased risk for the development of caries.

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

2. Patients with no clinical caries and not at increased risk for caries.
    a. Child – Primary Dentition:
    The Panel recommends that posterior bitewings be performed at an interval of 12-24 months if proximal surfaces cannot be examined visually or with a probe for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.
    b. Adolescent:
    The Panel recommends that posterior bitewings be performed at intervals of 12-24 months if proximal surfaces cannot be examined visually or with a probe for patients with a transitional dentition. Adolescents with permanent dentition posterior bitewing exam at 18-36-month intervals who show no clinical caries and are not at an increased risk for the development of caries.
    c. Adult – Dentulous:
    The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Recall Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult.

    Clinical judgement as to the need for and the type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, specific bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.

4. Growth and Development Assessment.
    a. Child – Primary Dentition:
    b. The Panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.
    c. Child – Transitional Dentition:
    The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.
    d. Adolescent: Permanent Dentition:
    The Panel recommends that for the adolescent (age 16-19 years of age) recall

patient, a single set of Periapicals of the wisdom teeth OR a panoramic radiograph. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.

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

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

Clinical situations for which radiographs may be indicated include but are not limited to:

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract (“fistula”)
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth

22. Clinical erosion

C. Factors increasing risk for caries may include but are not limited to:

1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects
11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multi surface restorations
15. Chemo/radiation therapy
16. Eating Disorders
17. Drug/alcohol abuse
18. Irregular dental care

17.00 Health Guidelines-Ages 0-18 Years

Recommendations for Prevenative Pediatric Dental Care (AAPD Reference Manual 2021)

Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)

Periodicity Recommendations					
Age	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Oral Hygiene Counseling	**Parents/ guardians/ caregivers**	**Parents/ guardians/ caregivers**	**Patient/parents/ guardians/ caregivers**	**Patient/ parents/ caregivers**	**Patient**
Injury, Prevention Counseling	X	X	X	X	X
Dietary Counseling	X	X	X	X	X
Counseling for non-nutritive habits	X	X	X	X	X
Fluoride Supplementation	X	X	X	X	X
Assess oral growth and development	X	X	X	X	X
Clinical oral exam	X	X	X	X	X

Periodicity Recommendations					
Prophylaxis	X	X	X	X	X
Assess systemic and topical fluoride status	X	X	X	X	X
Carries Risk Assessment	X	X	X		
Treatment of dental disease	X	X	X	X	X
Determine the interval for periodic reevaluation	X	X	X	X	X
Consult with physician as needed	X	X	X	X	X
Anticipatory guidance	X	X	X	X	X
topical fluoride treatment		X	X	X	X
Assess speech and language development and provider appropriate referral			X	X	X
Provide pit and fissure sealants for caries-susceptible anterior and posterior primary and permanent teeth			X	X	X
Radiographic assessment			X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Counseling and services as needed for orofacial trauma prevention			X	X	X
Substance abuse counseling				X	X
Provider counseling on intraoral/perioral piercings				X	X
Assessment and/or removal of third molars					X
Referral to general dentist for regular periodic dental care					X

18.00 Clinical Criteria for Child Health Plan Plus Child

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

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

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

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

These clinical criteria will be used for making medical necessity determinations for prior authorization requests (PARs), post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Covered Services Benefit Tables, Appendix B, Exhibit A in the "Review Required" column. For all procedures, every Participating Provider in the DentaQuest program is subject to random chart audits. Participating Providers are required to comply with any request for records. These audits may occur in the Participating Provider's office as well as in the office of DentaQuest.

Child Health Plan Plus Network Participating Providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please reference the "Patient Record" section for additional detail. Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed

partial dentures and crowns, on lays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled. Failure to provide the required documentation, adverse audit findings, report fraud, waste and abuse to HCPF program integrity unit or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Participating Provider from the DentaQuest Provider Panel.

18.01 Criteria for Dental Prophlaxis

Dental prophylaxis (i.e., teeth cleanings) is recommended every 6 months, and may be reimbursed twice per 12 months per member. Prophylaxis is not a benefit when billed on the same date of service as any periodontal procedure code.

To be covered by Child Health Plan Plus, dental prophylaxis must be performed and submitted in accordance with the ADA CDT manual description for D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis). These procedure codes are described as “removal of plaque, calculus, and stains from the tooth structure.” Claims for “toothbrush prophylaxis” should not be coded as D1110 or D1120, nor submitted for payment. Child Health Plan Plus does not reimburse for toothbrush prophylaxis.

18.02 Criteria for Topical Fluoride and Fluoride Varnish

Topical fluoride is a covered benefit for child members through age 18 and topical fluoride treatments are allowed twice (2) per year for child members.

18.03 Criteria for Sealants (ages 5 through 15 years old)

Sealants may be applied once per 36 months per tooth to the unrestored occlusal surface of any permanent first or second molar at risk for occlusal pit and fissure decay. A separate benefit will not be paid for sealant placed in the facial (buccal) pit and/or lingual groove of a permanent molar tooth. Sealants may be applied to all unrestored permanent molars without a cavitated lesion in child member’s ages 5 through 15 years old.

18.04 Criteria for Space Maintainers

- Removable and fixed space maintainers are performed to prevent tooth movement and maintain the space for eruption of a first or second premolar or permanent first molar when a primary tooth has been lost prematurely or for a congenitally missing permanent tooth for members up to the age of 13.

- The procedure is reimbursable once per arch per lifetime and includes any follow-up care and/or re-cementing, if necessary. Fixed space maintainers must be cemented prior to submitting a claim for reimbursement.

- Space maintainers are not reimbursable when the eruption of the permanent tooth is imminent.

- Removal of fixed space maintainers is allowed once per lifetime and is not payable within 6 months of original placement by the same Provider/dental office who delivered the appliance.

18.05 Criteria for Crowns

Prefabricated stainless-steel crowns, prefabricated resin crowns, and prefabricated stainless-steel crowns with a resin window are a benefit for both primary and permanent teeth for child and adult members.

Prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth.

When treating children under the age of 18, a maximum of five (5) crowns may be prepared and inserted on the same day of service in a non-hospital setting unless in-office sedation is provided. DentaQuest encourages providers to review the Dental Board rule XIV on Anesthesia, which includes the Code of Colorado Regulations, Rule on Anesthesia per the Department of Regulatory Agencies, Dentists and Dental Hygienists, 3 CCR 709-1, Section 1.14.

Documentation needed for pre-payment review of stainless-steel crown procedures:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapical or panoramic radiographic image.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

Crowns on a permanent tooth following root canal therapy must meet the following criteria:

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

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

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Authorization and treatment using Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay.
- An existing crown is present with chipped or fractured porcelain without decay.

18.06 Criteria for Endodontics

Covered Endodontic Services

- Therapeutic pulpotomy with the aim of maintaining the tooth vitality is a benefit for primary teeth and permanent teeth. It is not intended to be the first state of conventional root canal therapy.
- Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

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

Root canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries sub crestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- For child members (age 18 and younger): the tooth is a third molar.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and 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.
- Partial Pulpotomy for Apexogenesis is not considered the first part of Root Canal Therapy; and is only allowed on permanent teeth. Partial Pulpotomy for Apexogenesis requires removal of pulp and placement of medicament with the goal of maintaining vitality of the remaining portion to encourage continued physiological development and formation of the root.
- Retreatment of Previous Root Canal Therapy requires radiographic evidence of incomplete endodontic obturation, radiographic evidence of apical pathology and a narrative of symptomology consistent with failing root canal therapy.
- Apexification/Recalcification procedures includes opening of tooth, canal preparation and initial medication and closure. Interim appointments include medication change and closure. Final appointment includes completion of root canal therapy and closure and does not include final restoration. Includes all radiographs necessary at each step noted in this paragraph.
- Pulpal Regeneration includes opening of tooth, canal preparation and initial medication and closure. Interim appointments include medication change and closure. Does not include final restoration. Includes all radiographs necessary at each step noted in this paragraph.

18.07 Criteria for Removable Prosthodontics (Partial Dentures)

Removable prosthetics are not covered if eight (8) or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided for anterior teeth irrespective of the number of teeth in occlusion. Full and partial dentures require prior authorization. The member must be eligible at the time of treatment to receive payment.

Documentation needed for prior authorization (PAR) of removable prosthetics procedure(s):

- Treatment plan
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapical or panoramic images.

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

Criteria

- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not reference just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, Providers are expected to instruct the patient in the proper care of the prosthesis.
- Any adjustment necessary to achieve a proper fit during the six months immediately following the delivery of the prosthesis is included as part of the service.
- Denture adjustments are covered only when performed by a Provider who did not provide the denture.
- In general, for child members (age 18 and younger), if there is a pre-existing removable prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full-sized teeth.

Removable prosthesis will not meet criteria:

- For child members (age 18 and younger), if there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- For child members (age 18 and younger), if a partial denture, less than 5 years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

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

18.08 Criteria for Oral Surgery

Extractions of teeth that are involved with acute infection, acute pain, cyst, tumor or other neoplasm, radiographically demonstrable pathology that may fail to elicit symptoms.

Removal of third molars is only covered in instances of acute pain and overt symptomatology.

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

18.09 Criteria for Prior Authorization of Hospital or Outpatient Facility

Documentation needed for prior authorization of procedure:

- Treatment Plan
- Narrative describing medical necessity for Operating Room (OR).
- The word “HOSPITAL” written in box 35 Remarks on the current ADA claim form and **include the name and address of the participating hospital, ASC or facility**.

Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when such services are determined to be medically necessary. All Hospital or Outpatient Facility Cases Must be Authorized, all operating room cases must be prior-authorized, even if the complete treatment plan is not available.

When a prior authorization is reviewed for medical necessity for rendering services in a hospital setting or outpatient facility, DentaQuest will automatically add the CDT code D9500 to your claim. D9500 is not a covered code and no fee is attached to this code. Offices should refer to the determination status of the D9500 for indication of approval or denial of a hospital setting or outpatient facility. Once an approved authorization is obtained, the provider can schedule the eligible Child Health Plan Plus member for the dental services in a facility which accepts Child Health Plan Plus and in which he /she possess the appropriate staff privileges. Services must be rendered after the PAR is approved, during the authorization period. This is usually 180 days. Please reference the Provider Determination Letter for specific dates.

Criteria

- In most instances, Operating Room (OR) cases will be authorized (for procedures covered by Child Health Plan Plus) if the following is (are) involved:
- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, resent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Individuals with intellectual and/or developmental disabilities requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

If a dentist determines that a client needs hospitalization with or without associated general anesthesia, and meets one or more of the listed criteria, the dentist must:

1. Contact the client’s HMO or medical management department for prior authorization to use the hospital. The HMO may require documentation of medical necessity; or
2. If the client is not enrolled in an HMO, the dentist should make prior arrangements with a hospital or ambulatory surgery center that is a participating Child Health Plan Plus provider.
3. Check box number 38 (other) as the place of treatment on the current ADA paper claim form, or bill electronically via your Clearing House selecting either outpatient hospital or ambulatory surgery center as the place of treatment.
4. Bill any X-rays taken in either an outpatient hospital or ambulatory surgery center on the current ADA claim for or electronically via your Clearing House line itemizing X-ray procedures with other dental procedures. Hospital outpatient departments and ambulatory surgery centers are not allowed to bill for additional CPT codes for dental X-rays performed during outpatient dental procedures.
5. If billing on the DentaQuest Provider Web Portal (PWP):

6. Providers with hospital privileges only (not contracted at OR/Outpatient Facility location), bill services with the provider's primary office location, noting in remarks field the OR/facility name and address.
7. Providers who are contracted to the OR/Outpatient Facility location, bill services using the OR/facility name and location.
8. Additional costs for hospitals or ASC's are not covered.

18.10 Criteria for Orthodontics

Comprehensive orthodontic treatment is available only to Child Health Plan Plus child members age 18 and younger who qualify through the prior authorization process as having a severe handicapping labio-lingual deviation. Members are no longer eligible for any orthodontic benefits once they reach age 19.

The qualifying criteria for severe handicapping Labio-Lingual Deviation is listed in Appendix A – Handicapping Labio-Lingual Deviation Index Score Sheet.

Please note:

- To qualify, the member must have 12 months of continued coverage under CHP+. A pre-authorization denial stating the member does not have 12 months of continued coverage under the CHP+ program may be received. If verification through the HCPF Portal shows 12 months of continued coverage and the member has been active during that time, please follow the DentaQuest standard appeal process
- Orthodontic treatment is not a benefit to treat dental conditions that are primarily cosmetic in nature [10 C.C.R. 2505-10, Vol. 8.280.5.F].
- Orthodontic treatment is not a benefit when there is no severely handicapping labio-lingual deviation, and self-esteem is the primary reason for treatment [10 C.C.R. 2505-10, Vol. 8.280.5.F].
- The current ADA claim form is required for prior authorization requests (PARs) and claims.
- Orthodontists may use a wide range of services in the diagnosis, evaluation and treatment of orthodontic cases. Child Health Plan Plus does not pay for all types of services that can possibly be used **including cosmetic service, supply or material upgrades**.

    - Cosmetic service upgrades include, but is not limited to, clear bracket/aligner systems, such as Invisalign.

Orthodontic Services That Are Not Covered:

- Invisalign orthodontic treatment
- Limited orthodontic treatment codes D8010, D8020, D8030, D8040, D8050, D8060

Only dental providers enrolled with an orthodontic specialty designation are allowed to provide orthodontic treatment. Enrollment with this specialty designation requires an evaluation of your credentials. You will not be reimbursed for any orthodontic services rendered until you are enrolled by the Department as an Orthodontic specialist. See section 13.00 of this ORM for more information on provider credentialing and enrollment.

Comprehensive Orthodontia Please reference the most current CDT ADA publication for accepted descriptions of primary, transitional, adolescent, and adult dentitions. The Handicapping Labio-lingual Deviation Index Score Sheet will be used to determine medical necessity. Authorization for Orthodontia will be given if DentaQuest determines one or more criteria have been met.
The following documentation is required to show medical necessity:

- Handicapping Labio-lingual Deviation Index Score Sheet Lateral
- Cephalometric radiograph
- Panoramic radiograph
- Study models or OrthoCad equivalent or appropriate photographs

Appropriate photographic requirements include:

- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

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

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

DentaQuest will make the final determination for orthodontic treatment upon receipt of all the work-up materials as outlined above for the prior authorization process.

Prior Authorization Request (PAR) Effective Dates

PARs include span dates, which are the dates for which the PAR is effective. Providers will receive written notification of the approval or denial of a PAR. Included in this notification will be the effective date and end date of the PAR (span date). Approved Orthodontic PARs will be approved for 1080 days. Under no circumstances will an approved orthodontic PAR be valid after the member reaches the age 19. In order to be reimbursed for approved orthodontic services, the date of service on your claim must be within approved span dates on the PAR. Should the start of orthodontic treatment be delayed for any reason past the end date of the approved PAR, the Provider must submit a new PAR before starting treatment.

If the eligible child member's orthodontic treatment extends beyond the recipient's 19th birthday, it is the member's responsibility to pay for continued treatment. Acknowledgment of the member's understanding of this responsibility is required; please reference Section 8.10 Payment for Non-Covered Services for more information.

General Billing Information for Orthodontics:

Comprehensive Orthodontia

Once a PAR has been approved for comprehensive orthodontia, services may be rendered. Payment for comprehensive orthodontic treatment for eligible members will be made per the following schedule:

- Providers will be reimbursed one of D8070, D8080 or D8090 at banding.
- Providers will be reimbursed one D8670 on a date of service no earlier than 8 months after banding.
- Providers will be reimbursed one of D8680 at de-banding and retention no earlier than 18 months after banding.

Submit a claim for D8070, D8080, or D8090 on the date of banding.

The submission for D8670 must be at least nine months (or more) after banding and correspond with a date of service.
Submission of D8680 must correspond to the date of de-banding (must be at least eighteen months or more after banding).

During comprehensive orthodontia treatment, Providers will ONLY be paid for one D8070, D8080, or D8090; one D8670, and one D8680. Providers will also be able to collect the difference up to the approved orthodontic fee as an out of pocket payment from the member once comprehensive orthodontia has been approved.

If the child member does not return for the completion of services and there is documented failure to keep appointments by the child member, or for any other reason that orthodontic care needs to be terminated, the orthodontic provider must submit the Orthodontic Termination of Care Submission Form to DentaQuest (Appendix A). Recoupment of pre-paid fees will be determined by DentaQuest based upon the amount of treatment completed.

Lifetime Orthodontic Maximum
The current case rate will be the lifetime orthodontic benefit per member. DentaQuest will use the current case rate for transfer cases, rather than determining the case rate when the service was originally approved.

Lost or Damaged Bands, Brackets, Wires, Headgear
DentaQuest does not separately reimburse orthodontic providers to repair or replace bands, brackets, wires, headgear nor any other device normally associated with routine orthodontic care.

19.00 Direct Access/Independent Dental Hygiene Providers

Dental hygienists employed by a dentist, clinic or institution cannot submit claims directly to DentaQuest. Claims must be submitted using the enrolled employers National Provider Identification and Child Health Plan Plus Provider number.
Dental Hygienists may apply D1354- Silver Diamine Fluoride under the direct or indirect supervision of a dentist. RDH's must:

- Hold a license in good standing to practice dental hygiene
- Completes an interactive training course offered by a dental board-approved CE entity that addresses the use and limitations of silver diamine fluoride; is covered by professional liability insurance
- Has a collaborative agreement with a dentist that outlines the protocol, any restrictions/limitations, follow-up, and referral procedures for the use of silver diamine fluoride
- Maintain a copy of collaboration agreement with a licensed dentist on file for auditing purposes or possible investigation related to a complaint.

RDH TABLE- Child Health Plan Plus enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0120	Periodic oral evaluation-established patient

RDH TABLE- Child Health Plan Plus enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0140	Limited oral evaluation - problem focused, established patient
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
D0180	comprehensive periodontal evaluation - new or established patient
D0210	Intraoral - complete film series
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0270	Bitewing – single (1) film
D0272	Bitewings – two (2) films
D0273	Bitewings – three (3) films
D0274	Bitewings – four (4) films
D0277	Vertical Bitewings – seven (7) to eight (8) radiographic images
D0330	Panoramic radiographic image
D0350*	2D oral/facial photographic image obtained intra-orally or extra-orally
D1110	Prophylaxis – adult, ages twelve (12) years and older
D1120	Prophylaxis – child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride (e.g., gel)
D1351	Sealant (per tooth)
D1353	Sealant repair
D1354	Interim caries arresting medicament application- per tooth
D2940*	Protective restoration
D2941*	Interim therapeutic restoration-primary dentition
D4341	Periodontal Scaling and root planning – four or more teeth per quadrant
D4342	Periodontal Scaling and root planning – one to three teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal Maintenance
D9110	Palliative (emergency) treatment of dental pain- minor procedure

20.00 Teledentistry and ITR Billing Procedures

Child Health Plan Plus will reimburse DORA permitted RDH's for Protective Restorations and Interim Therapeutic Restorations (D2940 & D2941). Permitted RDH's must designate a supervising dentist that is currently enrolled with Child Health Plan Plus and within a reasonable proximity (30 miles - urban counties, 45 miles - rural counties, 60 Miles - frontier counties) of the location where the ITR is placed to ensure any follow-up care concerns can be addressed. Supervising dentists will be permitted to use code D0391 for their review of x-rays and photographs to make a diagnosis, treatment plan and order procedures such as an ITR. Please reference HB15-1309 for more information.

Supervising dentists and hygienists must provide documentation of the DORA permit and a signed notification of a supervising dentist form to Yvonne Castillo (yvonne.castillo@state.co.us) or their DentaQuest Provider Relations Representative to be allowed this reimbursement.

Code D9996 should be submitted whenever “store and forward” technology is used. This code enables HCPF to track and measure tele dentistry utilization.

Permitted RDH claims will trigger payment of the encounter rate, not the dentist claim for D0391. The RDH and the supervising dentist must work at the same FQHC.

Per HB15-1309 the RDH shall inform the member that appropriate follow up care with a Dentist is necessary

ITR Billing Information

Code	Description	Billing Information	Notes
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Billed by RDH	
D0391	Interpretation of diagnostic image by a practitioner not associated with the capture of the image, including report	Billed by Supervising dentist	Reimbursed at $0.00 for dentists working in a FQHC
D2940	protective restoration	Billed by RDH	
D2941	Interim therapeutic restoration - primary dentition	Billed by RDH	
D9996	asynchronous; information stored and forwarded to dentist for subsequent review	Billed by RDH	This code is used to determine Teledentistry utilization Reimbursement is $0.00

21.00 Dental Therapists

Dental procedures may be billed by a Dental Therapists within their scope of practice, as defined by the Colorado Department of Regulatory Agencies (DORA).

The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and enforces standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act under Dental Therapists. The Dental Practice Act and Board rules are available on DORA’s website → Professions→ Dentists, Dental Hygienists and Dental therapists. It is the provider's responsibility to ensure they are practicing, and subsequently billing, within their scope.

Child Health Plan Plus enrolled Dental Therapists must submit claims using the enrolled employers National Provider Identification and Child Health Plan Plus Provider Number.

Supervising dentists and dental therapists must provide documentation of the DORA permit and a signed notification of a supervising dentist form to Ivy Beville (Ivy.Beville@state.co.us) or their DentaQuest Provider Relations Representative to be allowed for reimbursement.

Additional Links:

- DORA DT checklist
- DORA apply online
- DORA verify license

DENTAL THERAPISTS TABLE- Child Health Plan Plus Enrolled Dental Therapist (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0120	periodic oral evaluation - established patient
D0140	limited oral evaluation-problem focused
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver
D0160	detailed and extensive oral eval-problem focused, by report
D0180	comprehensive periodontal evaluation - new or established patient
D0210	intraoral - comprehensive series of radiographic images
D0220	intraoral - periapical first radiographic image
D0230	intraoral - periapical each additional radiographic image
D0270	bitewing - single radiographic image
D0272	bitewings - two radiographic images
D0273	bitewings - three radiographic images
D0274	bitewings - four radiographic images
D0277	vertical bitewings - 7 to 8 films
D0330	panoramic radiographic image
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally
D1110	prophylaxis – adult
D1120	prophylaxis – child
D1206	topical application of fluoride varnish
D1208	topical application of fluoride - excluding varnish
D1351	sealant - per tooth
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.
D1353	Sealant repair - per tooth
D1354	interim caries arresting medicament application - per tooth
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1
D1702	"Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1
D1704	"Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2"
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	amalgam - three surfaces, primary or permanent
D2161	amalgam - four or more surfaces, primary or permanent
D2330	resin-based composite - one surface, anterior
D2331	resin-based composite - two surfaces, anterior
D2332	resin-based composite - three surfaces, anterior
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2391	resin-based composite - one surface, posterior
D2392	resin-based composite - two surfaces, posterior
D2393	resin-based composite - three surfaces, posterior
D2394	resin-based composite - four or more surfaces, posterior

DENTAL THERAPISTS TABLE- Child Health Plan Plus Enrolled Dental Therapist (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D2920	re-cement or re-bond crown
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	prefabricated stainless steel crown - primary tooth
D2931	prefabricated stainless steel crown-permanent tooth
D2932	prefabricated resin crown
D2933	prefabricated stainless steel crown with resin window
D2934	prefabricated esthetic coated stainless steel crown - primary tooth
D2940	protective restoration
D2941	Interim therapeutic restoration - primary dentition
D4341	periodontal scaling and root planing - four or more teeth per quadrant
D4342	periodontal scaling and root planing - one to three teeth per quadrant
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit
D4910	periodontal maintenance procedures
D7111	extraction, coronal remnants - primary tooth
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D9110	palliative (emergency) treatment of dental pain - minor procedure

Appendix A

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

A. The Department" means the Colorado Department of Health Care Policy and Financing, which serves as Child Health Plan Plus Single State Agency, as defined by the Code of Federal Regulations (CFR) Title 45 Section 2015.100 (45 CFR §205.100).

B. Contract" means the document specifying the services provided by DentaQuest to:
   - an employer, directly or on behalf of the State of Colorado, as agreed upon between The Department and DentaQuest (a "Government Contract");
   - a Child Health Plan Plus beneficiary, directly or on behalf of The Department, as agreed upon between the State of Colorado or its regulatory agencies and DentaQuest (a "Child Health Plan Plus Contract");

C. a Medicare beneficiary, directly or on behalf of The Department, as agreed upon between the Center for Medicare and Child Health Plan Plus Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

D. "Covered Services" is a dental service or supply that satisfies all of the following criteria:
   - provided or arranged by a Participating Provider to a member;
   - authorized by DentaQuest in accordance with the Plan Certificate; and
   - submitted to DentaQuest according to DentaQuest's filing requirements.

E. "DentaQuest" shall reference DentaQuest, USA Insurance Company, Inc.

F. "DentaQuest Service Area" shall be defined as the State of Colorado.

G. "Dental Professional" is a Participating Provider who is enrolled dental professional with Child Health Plan Plus. The types of dental professional providers who can render these services are dentists and dental hygienists who are licensed in Colorado.

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

I. "Member" means any individual who is eligible to receive Child Health Plan Plus Covered Services pursuant to the Department's benefit scope, frequencies and limitations as outlined in this ORM.

J. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with the Colorado Department of Health Care Policy and Financing, directly or through another entity, to provide dental services to selected groups of members.

K. “Plan” is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members for a fixed prepaid fee.
L. “Plan Certificate” means the document that outlines the benefits available to members.

M. Provider" means the undersigned health professional or any other entity that has entered into a written agreement with the Colorado Department of Health Care Policy and Financing to provide certain health services to members. Each Provider shall have its own distinct tax identification number.

N. “Provider Dentist” is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed an Agreement with the Colorado Department of Health Care Policy and Financing.

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The link below provide different methods to access and acquire both electronic and printable forms addressed within this document. To view copies online please visit our website at www.DentaQuest.com. The online forms can be viewed on the Colorado CHP+ Provider Page under the side tab called forms. You may also choose to send in the following resources below which are attached to this Office Reference Manual.

- Current ADA Claim Form
- ADA Dental Claim Form Instructions
- Dental Non-Covered Service Disclosure Form – English
- Dental Non-Covered Service Disclosure Form – Spanish
- Direct Deposit/ACH Authorization Form
- Medical/Dental History Form
- Member Consent For Appeal
- Authorization for Dental Treatment Form
- Initial Clinical Exam Form
- Request for Transfer of Records Form
- Recall Examination Form
- Handicapping Labio-Lingual Deviation Index Score Sheet – Comprehensive Treatment (D8070, D8080, D8090) Form

If you do not have internet access you may also contact DentaQuest Provider Services at 855.225.1731 in order to have copies of the “Related Documents” listed under Additional Resources mailed to you.

American Dental Association Dental CLAIM FORM

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F ☐U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

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

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

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

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F ☐U	15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

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

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

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

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=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	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

DentaQuest

American Dental Association Dental Claim Form Instructions

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"

DentaQuest

Colorado Child Health Plan Plus (Colorado's CHIP Program)

Dental Non-Covered Service Disclosure Form - English

Colorado Child Health Plan Plus (Colorado's CHIP Program) members may purchase additional dental services as non-covered procedure(s) or treatment(s) for an additional fee. CHIP requires that the participating provider and the member complete the Colorado Child Health Plan Plus Dental Non-Covered Services Disclosure Form prior to rendering these services. A copy of this completed and signed form must be kept in the member's treatment record. If the member elects to receive the non-covered procedure(s) or treatment(s) the member will be charged a fee, not to exceed the maximum rate of the participating provider's Usual and Customary Fees (UCF), as payment in full for the agreed procedure(s) or treatment(s).

The member is financially responsible for such non-covered service(s) or treatment(s) as defined by the CHIP Program in section 4.10 of the DentaQuest Office Reference Manual (ORM). The member may be subject to collection action upon failure to make the required payment. If the member is subject to collection action, the terms of the action must be kept in the member's treatment record.

Failure to comply with the Colorado Child Health Plan Plus policy regarding non-covered services and member billing will subject the participating provider to sanctions up to and including termination as outlined in State statues (CRS 25.5-4-301)

This section to be completed by the participating provider rendering dental care:

I have done my due diligence on behalf of the member and educated the member about their covered benefits and informed the member that these procedure(s) may not be paid by Colorado Child Health Plan Plus.
I am recommending:

_____

(Member Name and CHIP Number)
receive services that are not covered by the Colorado Child Health Plan Plus Dental Program and Fee Schedule.

The Colorado Child Health Plan Plus dental program encourages participating providers to bill members at or near the current fee schedule amount (FEES ARE NOT TO EXCEED PROVIDER'S UCF.) The following procedure codes are recommended:

Procedure Code (If applicable)	Description	Fee	Date(s) of Service

Procedure Code (If applicable)	Description	Fee	Date(s) of Service

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

Participating Provider's Signature _____ Date _____

NOTE: Any provider-created agreement must include all of the data elements listed on this form.

This section to be completed by the member:

I _____ have been told that I require, or I have
Print Member Name
requested, dental services that are not covered by Colorado Child Health Plan Plus.

Read the following statements and check Yes or No:

	Yes	**No**
1. My dental provider has assured me that there are no other covered benefits available to me as an alternative treatment option(s).	____	____
2. I am willing to receive services not covered by Colorado Child Health Plan Plus	____	____
3. I am aware that I am financially responsible for paying for these services.	____	____
4. I am aware that Colorado Child Health Plan Plus is not paying for these services.	____	____

I agree to pay $_____ per month towards the total amount due to my dental provider for the services rendered as outlined in this agreement. If I fail to make this payment, I may be subject to collection action by the participating provider.

_____

Member Signature Date

_____

Parent or Guardian Signature, if under 18. Date

Colorado Child Health Plan Plus (Programa CHIP de Colorado)

Formulario de divulgación para servicios dentales no cubiertos

Los afiliados de Colorado Child Health Plan Plus (Programa CHIP de Colorado) pueden adquirir servicios dentales adicionales como procedimientos o tratamientos no cubiertos por una tarifa adicional. CHIP exige que el proveedor participante y el afiliado diligencien el **Formulario de divulgación para servicios dentales no cubiertos de Colorado Child Health Plan Plus** antes de proporcionar estos servicios. **Se debe conservar** una copia de este formulario diligenciado y firmado en el historial de tratamiento del afiliado. Si el afiliado decide recibir los procedimientos o tratamientos no cubiertos, se le cobrará una tarifa que no superará la tarifa máxima de los honorarios usuales y acostumbrados (*UCF, Usual and Customary Fees*) del proveedor participante como pago total por los procedimientos o tratamientos acordados.

El afiliado es responsable económicamente de dichos servicios o tratamientos no cubiertos, según lo define el Programa CHIP en la sección 4.10 del Manual de referencia para consultorios (*ORM, Office Reference Manual*) de DentaQuest. El afiliado puede ser objeto de una acción de cobro en caso de no efectuar el pago requerido. Si el afiliado es objeto de una acción de cobro, los términos de la misma deben conservarse en el historial de tratamiento del afiliado.

El incumplimiento de la política de Colorado Child Health Plan Plus relacionada con los servicios no cubiertos y a la facturación a los afiliados expondrá al proveedor participante a sanciones que pueden llegar incluso al despido, según se establece en la legislación estatal (CRS 25.5-4-301).

Esta sección debe ser completada por el proveedor participante que proporciona la atención dental:

He actuado con la diligencia debida en nombre del afiliado, le he explicado los beneficios cubiertos y le he informado que estos procedimientos no pueden ser pagados por Colorado Child Health Plan Plus.

Recomiendo que:

_____

(Nombre y número CHIP del afiliado)

reciba servicios que **no** están cubiertos por el Programa dental ni la Tabla de honorarios de Colorado Child Health Plan Plus.

El Programa dental de Colorado Child Health Plan Plus dental recomienda a los proveedores participantes que facturen a los afiliados una cantidad igual o cercana a la cantidad indicada en la tabla de honorarios vigente (LAS TARIFAS NO DEBEN SUPERAR EL UCF DEL PROVEEDOR). Se recomiendan los siguientes códigos de procedimiento:

Código de procedimiento (si aplica)	Descripción	Tarifa	Fechas de los servicios:

La cantidad total por el servicio que se proporciona es $_____.

_____

Firma del proveedor participante Fecha

NOTA: Cualquier acuerdo creado por el proveedor debe incluir todos los elementos de datos incluidos en este formulario.

Esta sección debe ser completada por el afiliado:

Yo, _____/_____, declaro que se me ha dicho que
Nombre del afiliado en letra de molde
requiero, o que he solicitado, servicios dentales que no están cubiertos por Colorado Child Health Plan Plus.

Lea con atención los siguientes puntos y marque Sí o No: Sí No

1. Mi proveedor dental me ha asegurado que no existen otros beneficios cubiertos a mi disposición como opciones alternativas de tratamiento.
2. Estoy dispuesto a recibir servicios no cubiertos por el Programa dental de Colorado Child Health Plan Plus.
3. Soy consciente de que soy responsable económicamente del pago de estos servicios.
4. Soy consciente de que Colorado Child Health Plan Plus no va a pagar estos servicios.

Acepto abonar $_____ al mes hacia la cantidad total adeudada a mi proveedor dental por los servicios proporcionados según se indica en el presente acuerdo. Si no hago este pago, puedo ser objeto de una acción de cobro por parte del proveedor participante.

_____

Firma del afiliado Fecha

_____

Firma del padre o tutor si es menor de 18 años Fecha

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	
*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		

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

_____

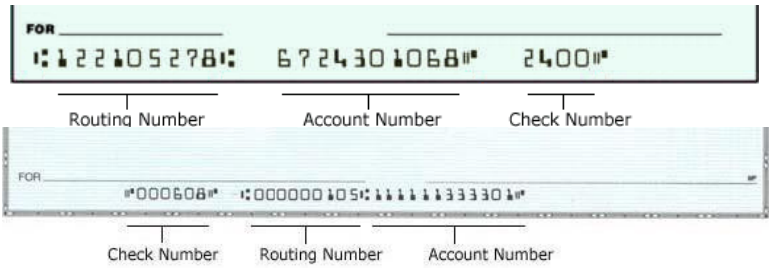
Printed Title of Person Submitting Enrollment

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**.**



Personal Checking

Business Checking

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

MEDICAL AND DENTAL HISTORY

Patient Name: _____

Legal Name: _____

Gender: _____ Date of Birth: _____/_____/_____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

____ Yes ____ No

If yes, please list: _____

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

Do your ankles swell during the day? ____ Yes____ No

Do you use more than two pillows to sleep? ____ Yes____ No

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

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

Are you on a special diet? ____ Yes____ No

Has your medical doctor ever said you have cancer or a tumor? ____ Yes____ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ____ Yes____ No

If yes, how often and how much? _____

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

Do you have, or have you had any disease, or condition not listed? ____ Yes____ No

If yes, please list: _____

Do you have, or have you had, any complex medical needs that would affect your dental care? ____ Yes____ No

If yes, please explain: _____

_____

Do you require any special accommodations for your dental care? ____ Yes____ No

If yes, please list: _____

_____

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

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

For Women Only:

Are you pregnant? ____ Yes ____ No

If yes, what month? _____

Are you nursing? ____ Yes ____ No
Are you taking birth control pills? ____ Yes ____ No

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

Patient Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Review Date	Changes in Health Status	Patient's signature	Provider's signature

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

Member Consent For Appeal

Member Name: _____

Member ID: _____

Provider Name: _____

I have authorized the provider listed above to act for me in the appeal for services with DentaQuest. I authorize the provider to make the request, present evidence relating to the appeal, to obtain appeals information, and to receive any notice in connection with my appeal. I understand that personal information related to my appeal may be discussed with my provider.

Member Signature

Date

Summary of Appeal:

DentaQuest

Authorization for Dental Treatment

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

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

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

I realize that it is mandatory that I follow any instructions given by the Provider 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 Provider.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Provider: _____

Patient Name: _____

Legal Guardian/ Patient Signature: _____

Witness: _____

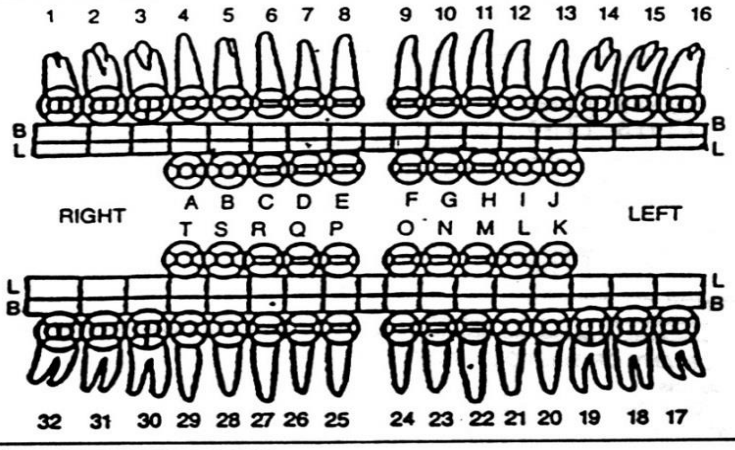
Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please reference State statutes for specific State requirements and guidelines.

INITIAL CLINICAL EXAM FORM

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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: _____

RECALL EXAMINATION

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

_____

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

RADIOGRAPHS	B/P	RDH/DDS

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

COMMENTS: _____

_____

_____

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

DentaQuest

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET	
Name (Last, First):_____Medicaid ID: _____DOB: _____	
All necessary dental work completed? Yes_____No____Patient oral hygiene: Excellent_____Good _____Poor___ **(all dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)**	
PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler): • Indicate by checkmark next to A or B which criteria you are submitting for review • Position the patient's teeth in centric occlusion; • Record all measurements in the order given and round off to the nearest millimeter (mm); • ENTER SCORE "0" IF CONDITION IS ABSENT	
A.____CONDITIONS 1-6 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)	
1. Congenital or developmental dental deformity	_____
2. Deep impinging overbite when lower incisors are destroying the soft tissue of the palate.	_____
3. Crossbite of individual anterior teeth when destruction of the soft tissue is present.	_____
4. Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm.	_____
5. Severe traumatic deviations.	_____
6. Surgical malocclusion with orthognathic surgery	_____
Continue to scoring below is there are no qualifying conditions checked above	
B.____CONDITIONS 1-9 MUST SCORE 30 POINTS OR MORE TO QUALIFY	
1. Overjet in mm.	mm_____- 2 = _____

2. Overbite in mm.	mm_____- 3 = _____
3. Reverse overjet of 3.5 mm or less	_____x 1 = _____
4. Impacted cuspids that will not erupt into the arches without orthodontic or surgical intervention.	_____x 1 = _____
5. Anterior openbite in mm.	_____x 4 = _____
If both anterior crowding and ectopic eruptions are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.	
6. Ectopic eruption: Count each tooth, excluding third molars	_____x 3 = _____
7. Anterior crowding: Anterior arch length insufficiency must exceed 3.5mm; score one point for maxilla and one point for mandible; 2 points maximum for anterior crowding. The maximum number of points for this item is therefore 10 points (5 upper and 5 lower).	_____x 5 = _____
8. Labio-lingual Spread: Measure the distance between the most protruded tooth and the normal archline or most lingually displaced adjacent anterior tooth.	_____x 1 = _____
9. Posterior unilateral crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the scoresheet.	Score 4 = _____
TOTAL SCORE (must score 30 points or more to qualify)	_____

Appendix B

Covered Services Benefit Tables (See Exhibit A)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for members under the various Child Health Plan Plus plan. Providers with benefit questions should contact DentaQuest's Provider Service department directly at:

855.225.1731

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

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

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

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

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the American Dental Association (ADA) Current Dental Terminology (CDT) code manual.

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

1. The ADA approved CDT procedure code to submit when billing.
2. A brief description of the covered service.
3. Any age limits imposed on coverage.
4. A description of documentation, in addition to a completed Current 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 (PAR) and any other applicable benefit limitations

ORM CHANGE LOG – Exhibit A

Child Health Plan Plus

Revision Date	Effective Date	Section	CDT Code	Detail
3.23.20	3.23.20	Exhibit A	D0350	Frequency limitation: 1 (D0350) per 12 months
4.6.20	3.23.20	Exhibit A	D9995	Added for use during COVID 19 Frequency limitation: 2 (D9995) per month, per patient, maximum of 6 per lifetime.
5.11.20	3.1.20	8.10		Updated Payment for Non-Covered Services and Billing Members Section to include PPE language.
6.26.20		8.13		Added Provider Appeal Rights Clarification
6.26.20		8.13 and 10.00		NOTE: Overpayment recoupments listed on your EOBs will not be made for 60 days to allow for an appeal.
10.9.20	3.23.20	Exhibit A	D0350	Added required teeth numbers
10.9.20	10.31.20	Exhibit A	D9995	Removed COVID/Emergency requirement. Removed PPR designation.
11.23.20	12.1.20	8.13		Added Provider Appeal definitions
11.23.20	12.1.20	Page 68		Added Member Consent for Appeal form
1.28.21	7.1.2019	Exhibit A	D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment
9.10.21	9.10.21	Exhibit A	D1701 D1702 D1703 D1704 D1707	Adding vaccination codes and fees to the covered benefits to the Child benefits

7.15.22	7.15.22	Exhibit A	D0150	Benefit Limitation Update: One of (D0120, D0145, D0150, D0160) per 36 month(s) Per Provider or Location
2.12.24	2.12.24	Exhibit A	D0350	Benefit Limitation Update: Removal of teeth numbers and changing the frequency to One of (D0350) 6 times per 12 months per patient

Diagnostic series 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 x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for the individual radiographs taken on the same day will be limited to the allowance for a full mouth series. A minimum of 10 films is required for an intraoral complete series (full mouth series). A panoramic film with or without bitewing radiographs is considered equivalent to an intraoral complete series and cannot be billed on the same date of serves as a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitation. 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**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160) per 12 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160) per 12 Month(s) Per patient.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160) per 12 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	0-18		No	No	One of (D0120, D0145, D0150, D0160) per 36 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	No	One of (D0120, D0140, D0145, D0150, D0160) per 12 Month(s) Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	No	One of (D0180) per 12 Month(s) Per patient. Two of (D0120, D0150, D0180) per 12 Month(s) Per Provider OR Location.	
D0210	intraoral - comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-18		No	No	Six of (D0220) per 12 Month(s) Per patient. Not reimbursable on same day as D0210.	

Exhibit A Benefits Covered for CO Child Health Plan Plus

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	No	Working and final endodontic treatment films are included in the endo codes . Not covered if billed with D3310, D3320, D3330. Not allowed on the same day as D0210.	
D0270	bitewing - single radiographic image	0-18		No	No	Two of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per patient. Bitewings processed as part of an intraoral-complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.	
D0272	bitewings - two radiographic images	0-18		No	No	Two of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per patient. Bitewings processed as part of an intraoral-complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.	
D0273	bitewings - three radiographic images	0-18		No	No	Two of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per patient. Bitewings processed as part of an intraoral-complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.	
D0274	bitewings - four radiographic images	0-18		No	No	Two of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per patient. Bitewings processed as part of an intraoral-complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.	
D0277	vertical bitewings - 7 to 8 films	0-18		No	No	Two of (D0270, D0272, D0273, D0274, D0277) per 12 Month(s) Per patient. Bitewings processed as part of an intraoral-complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.	

Exhibit A Benefits Covered for CO Child Health Plan Plus

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	No	Six of (D0350) per 12 Month(s) Per patient. RDH's will receive reimbursement when used for telehealth dentistry in partnership with a treating dentist.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No	No	One of (D0391) per 1 Month(s) Per Provider.	

Sealants may be placed on the unrestored occlusal surfaces of lower and upper permanent molars without a cavitated lesion. Space maintainers are a covered service when determined by a DentaQuest consultant to be medically indicated due to the premature loss of a posterior primary tooth, permanent first molar or congenitally missing permanent tooth. A lower lingual hold arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance. Fees for space maintainers include maintenance and repair.

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

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	12-18		No	No	Two of (D1110, D1120, D4910) per 12 Month(s) Per patient.	
D1120	prophylaxis - child	0-11		No	No	Two of (D1110, D1120, D4910) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	0-18		No	No	Two of (D1206, D1208) per 12 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	6-18		No	No	Two of (D1206, D1208) per 12 Month(s) Per patient.	
D1351	sealant - per tooth	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351, D1352, D1353) per 36 Month(s) Per patient per tooth. On unrestored occlusal surfaces of permanent molar teeth.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351, D1352, D1353) per 36 Month(s) Per patient per tooth. On unrestored occlusal surfaces of permanent molar teeth.	
D1353	Sealant repair - per tooth	5-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351, D1352, D1353) per 36 Month(s) Per patient per tooth. On unrestored occlusal surfaces of permanent molar teeth.	
D1354	application of caries arresting medicament- per tooth	0-18	Teeth 1 - 32, A - T	No	No	Two of (D1354) per 12 Month(s) Per patient per tooth.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510, D1520) per 1 Lifetime Per patient per quadrant.	
D1516	space maintainer --fixed--bilateral, maxillary	0-13	Per Arch (01, UA)	No	No	One of (D1516, D1526) per 1 Lifetime Per patient per arch.	

Exhibit A Benefits Covered for CO Child Health Plan Plus

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-13	Per Arch (02, LA)	No	No	One of (D1517, D1527) per 1 Lifetime Per patient per arch.	
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510, D1520) per 1 Lifetime Per patient per quadrant.	
D1526	space maintainer --removable--bilateral, maxillary	0-13	Per Arch (01, UA)	No	No	One of (D1516, D1526) per 1 Lifetime Per patient per arch.	
D1527	space maintainer --removable--bilateral, mandibular	0-13	Per Arch (02, LA)	No	No	One of (D1517, D1527) per 1 Lifetime Per patient per arch.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-13		No	No	One of (D1551) per 12 Month(s) Per patient. Not reimbursable within 6 months of original placement by same dentist or group.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-13		No	No	One of (D1552) per 12 Month(s) Per patient. Not reimbursable within 6 months of original placement by same dentist or group.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1553) per 1 Lifetime Per patient per quadrant. Not reimbursable within 6 months of original placement by same dentist or group.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-18		No	No	One of (D1701) per 1 Lifetime Per patient. Please refer to the CDC guidelines for the most up to date and current guidelines and information.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-18		No	No	One of (D1702) per 1 Lifetime Per patient. Please refer to the CDC guidelines for the most up to date and current guidelines and information.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-18		No	No	One of (D1703) per 1 Lifetime Per patient. Please refer to the CDC guidelines for the most up to date and current guidelines and information.	

Exhibit A Benefits Covered for CO Child Health Plan Plus

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-18		No	No	One of (D1704) per 1 Lifetime Per patient. Please refer to the CDC guidelines for the most up to date and current guidelines and information.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-18		No	No	One of (D1707) per 1 Lifetime Per patient. Please refer to the CDC guidelines for the most up to date and current guidelines and information.	

Reimbursement includes local anesthesia. Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 months. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, 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 and curing are included as part of the restoration. An amalgam or composite restoration and a crown on the same tooth and on the same date of service is not allowed. Prefabricated stainless steel crowns are a benefit for both primary and permanent teeth. Prefabricated resin crowns, prefabricated stainless steel crowns with resin window and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. Cast crown materials are limited to porcelain and noble metal or full porcelain on anterior teeth and premolars. Full noble metal crowns will be the material of choice for molars. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery date.

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**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	

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Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D2920) per 1 Lifetime Per patient per tooth. Not payable within 6 months of placement.	

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Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-18	Teeth A - T	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-18	Teeth A - T	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	0-18	Teeth 1 - 32	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-18	Teeth C - H, M - R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth.	
D2940	protective restoration	0-18	Teeth 1 - 32, A - T	No	No	One of (D2940) per 24 Month(s) Per patient per tooth.	
D2941	Interim therapeutic restoration - primary dentition	0-18	Teeth A - T	No	No	One of (D2941) per 1 Lifetime Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No	No	One of (D2951) per 24 Month(s) Per patient per tooth. Only allowed with D2140-D2161, D2330-D2335, or D2391-D2394 on the same date of service.	

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. A pulpotomy, pulpal debridement or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filing material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra operative and final radiographs.

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

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	

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Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351 and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form.

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**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. Subject to Pre-payment review	Perio Charting, pre-op radiographs and narr of med necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. Subject to Pre-payment review	Perio Charting, pre-op radiographs and narr of med necessity
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32	No	Yes	One of (D4277, D4278) per 36 Month(s) Per patient per tooth. Subject to Pre-payment review	narrative of medical necessity
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	No	Yes	One of (D4277, D4278) per 36 Month(s) Per patient per tooth. Subject to Pre-payment review	narrative of medical necessity
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 3 Year(s) Per patient per quadrant. Subject to Pre-payment review	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D4341, D4342) per 3 Year(s) Per patient per quadrant. Subject to Pre-payment review	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	0-18		No	Yes	One of (D4346) per 12 Month(s) Per patient. Not reimbursed when billed on the same date of service as (D1110, D1120, D4341, D4342, D4355, D4910). Subject to pre-payment review.	narrative of medical necessity

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Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	13 - 18		No	Yes	One of (D4355) per 3 Year(s) Per patient. (D0150, D0160, D0180, D1110, D1120) are not reimbursable when provided on the same day of service as (D4355). (D4355) is not reimbursable if patient record indicates (D1110, D1120) have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as (D4355).Subject to pre-payment review	narrative of medical necessity
D4910	periodontal maintenance procedures	0-18		No	Yes	Two of (D1110, D1120, D4346, D4910) per 12 Month(s) Per patient. Subject to Pre-payment review	Perio Charting, pre-op radiographs and narr of med necessity

Removable prosthetics are not covered if eight or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided for anterior teeth irrespective of the number of teeth in occlusion. Maxillofacial prostheses that serve to rehabilitate esthetics and function for member with acquired, congenital or developmental defects of the head and next are covered. Necessary prostheses to restore both form and function is covered for members exposed to chemotherapy, radiation or cytotoxid drugs. Services for removable prostheses must include instruction in the use and care of the prosthesis and any adjustments necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery date.

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

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		No	Yes	One of (D5211) per 60 Month(s) Per patient per arch. Subject to Pre-payment review	narr. of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		No	Yes	One of (D5212) per 60 Month(s) Per patient per arch. Subject to Pre-payment review	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (maxillary)	0-18		No	Yes	One of (D5820) per 60 Month(s) Per patient. Subject to Pre-payment review	narr. of med. necessity, pre-op x-ray(s)
D5821	interim partial denture-mandibular	0-18		No	Yes	One of (D5821) per 60 Month(s) Per patient. Subject to Pre-payment review	narr. of med. necessity, pre-op x-ray(s)

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

Maxillofacial Prosthetics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D5932	obturator prosthesis, definitive	0-18		No	Yes	Subject to Pre-payment review	narrative of medical necessity

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. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Covered dental services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form.

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**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T	No	No	One of (D7111) per 1 Lifetime Per patient per tooth.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Yes	One of (D7210) per 1 Lifetime Per patient per tooth. Subject to Pre-payment review	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Yes	One of (D7220) per 1 Lifetime Per patient per tooth. Subject to Pre-payment review	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Yes	One of (D7230) per 1 Lifetime Per patient per tooth. Subject to Pre-payment review	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Yes	One of (D7240) per 1 Lifetime Per patient per tooth. Subject to Pre-payment review	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1, 16, 17, 32	No	Yes	One of (D7241) per 1 Lifetime Per patient per tooth. Subject to Pre-payment review	pre-operative x-ray(s)

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Member may not be billed for broken, repaired or replacement of brackets or wires. The member must be eligible in order for payments to be made.

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

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D8070	comprehensive orthodontic treatment of the transitional dentition	0-18		Yes	No	One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Additional required documentation: HLD Index Form.	Photos, Narrative/treatment plan
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Additional required documentation: HLD Index Form.	Photos, Narrative/treatment plan
D8090	comprehensive orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Additional required documentation: HLD Index Form.	Photos, Narrative/treatment plan
D8670	periodic orthodontic treatment visit	0-18		Yes	No	One of (D8670) per 1 Lifetime Per patient. Must be billed at least 9 months after D8070, D8080, D8090 and be billed on a DOS.	
D8680	orthodontic retention (removal of appliances)	0-18		Yes	No	One of (D8680) per 1 Lifetime Per patient. Must be billed at least 18 months after D8070, D8080, D8090 and must be billed on a DOS.	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-18		Yes	No	One of (D8695) per 1 Lifetime Per patient.	narrative of medical necessity

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

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required (PAR)**	**Pre Payment Review (PPR)**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-18		No	No	Not reimbursable with any other services other than radiographs necessary for diagnosis. Not reimbursable when the only other service is writing a prescription.	
D9440	office visit - after regularly scheduled hours	0-18		No	Yes	Subject to Pre-payment review	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-18		No	No	Two of (D9995) per 1 Month(s) Per patient. This code will only pay by itself or with a D0140	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-18		No	No	This code is used to determine Teledentistry utilization. Reimbursement is $0.	