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

Anthem Blue Cross and Blue Shield Medicaid (Anthem)

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

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

http://www.DentaQuest.com/Kentucky

AKYPEC-1017-16 October 2016

DentaQuest of Kentucky, Inc.
Address and Telephone Numbers

DentaQuest Corporate Office Address:
P.O. Box 2906
Milwaukee, WI 53201-2906

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

Fax numbers:
- **Claims to be processed:**
  (262) 834-3589

Email Addresses:
- **Claims Questions:**
  denclaims@DentaQuest.com

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

Fraud Hotline:
- **(800) 237-9139**

Review & Referral Requests should be sent to:
DentaQuest – UM Department
12121 North Corporate Parkway
Mequon, WI 53092

Credentialing:
12121 North Corporate Parkway
Mequon, WI 53092
Fax: (262) 241-4077

Credentialing Hotline:
- **(800) 233-1468**

General TTY Number:
- **(800) 466-7566**

Anthem TTY Number:
- **(800) 855-2880**

Claims should be sent to:
DentaQuest - Claims
12121 North Corporate Parkway
Mequon, WI 53092

Electronic Claims should be sent:
Direct entry on the web – www.DentaQuest.com
Or,
Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
12121 N Corporate Parkway
Mequon, WI 53092

Short Procedure Unit (SPU) for review of Operating Room (OR) cases:
DentaQuest - SPU Department
P.O. Box 339 Mequon, WI 53092
Fax line: (262) 834-3575

Kentucky Member Services:

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

- **Anthem: (855) 690-7784**

DentaQuest of Kentucky, Inc.

The Kentucky Patient's Bill of Rights and Responsibilities

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

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

DentaQuest of Kentucky, Inc. ("DentaQuest")

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

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

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DentaQuest.

3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest

4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by Plan/DentaQuest.

6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service prior to treatment.

7. To be informed of the status of their credentialing or recredentialing application, upon request.

* * *

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

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

Office Reference Manual
Table of Contents

Section		Page
1.00	Introduction	8
2.00	General Definitions	8
3.00	Patient Eligibility Verification Procedures	11
3.01	Plan Eligibility	11
3.02	Member Identification Card	11
3.03	DentaQuest's Eligibility Systems	12
4.04	Emergency Care Requirements (All Plans)	13
5.00	Participating Hospitals	15
5.01	Hospital Case Management	15
5.03	Payment for Non-Covered Services	15
6.00	Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data	15
6.01	Electronic Attachments	16
6.02	Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review	16
6.03	Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Internet Website	17
6.04	Electronic Claim Submission via Clearinghouse	17
6.05	HIPAA Compliant 837D File	17
6.06	NPI Requirements for Submission of Electronic Claims	18
6.07	Paper Claim Submission	18
6.08	Coordination of Benefits (COB)	19
6.09	Filing Limits	19
6.10	Receipt and Audit of Claims	19
6.11	Direct Deposit	19
6.12	Provider Recognition in State Medicaid Program	20
7.00	Health Insurance Portability and Accountability Act (HIPAA)	20
7.01	HIPAA Companion Guide	21

8.00 Member & Provider Inquiries, Complaints, Grievances & Appeals (Policies 200 Series) . 21

9.00 Utilization Management Program (Policies 500 Series) 23

9.01 Community Practice Patterns 23

9.02 Evaluation 24

9.03 Results 24

9.04 Fraud and Abuse (Policies 700 Series) 24

10.00 Quality Improvement Program (Policies 200 Series) 24

11.00 Credentialing (Policies 300 Series) 26

11.01 Termination 26

12.00 The Patient Record 27

13.00 Patient Recall System Requirements 30

14.00 Radiology Requirements 31

14.01 Criteria for Radiographs 34

15.00 Recommended Health Guidelines – Periodic Schedules (Ages 0-18 Years) 35

16.00 Clinical Criteria 36

16.01 Criteria for Dental Extractions 36

16.02 Criteria for Cast Crowns 38

16.03 Criteria for Endodontics 39

16.04 Criteria for Stainless Steel Crowns 40

16.05 Criteria for Review of Operating Room (OR) Cases 42

16.06 Criteria for Removable Prosthodontics (Full and Partial Dentures) 43

16.07 Criteria for the Excision of Bone Tissue 45

16.08 Criteria for the Determination of a Non-Restorable Tooth 45

16.09 Criteria for General Anesthesia and Intravenous (IV) Sedation 45

16.10 Criteria for Periodontal Treatment 46

16.11 Clinical Criteria for Orthodontics 47

18.00 Cultural Competency Program 51

19.00 Reimbursement of Services Rendered 53

APPENDIX A..... Attachments

Additional Resources A-1

APPENDIX B ..... Covered Benefits

Member's Covered Benefits ……..B-1
DentaQuest Review Process…….....B-2

1.00 Introduction

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

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

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

2.00 General Definitions

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

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

a) Decides a proposed or delivered health care service, which would otherwise be covered under this Agreement is not, or was not medically necessary, appropriate or efficient; and
b) May result in non-coverage of the health care service.
Adverse determination does not include a decision concerning a subscriber's status as a member.

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

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

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

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

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

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

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

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

DentaQuest Service Area: the Commonwealth of Kentucky.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Plan: refers to DentaQuest of Kentucky, Inc.

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

3.00 Patient Eligibility Verification Procedures

3.01 Plan Eligibility

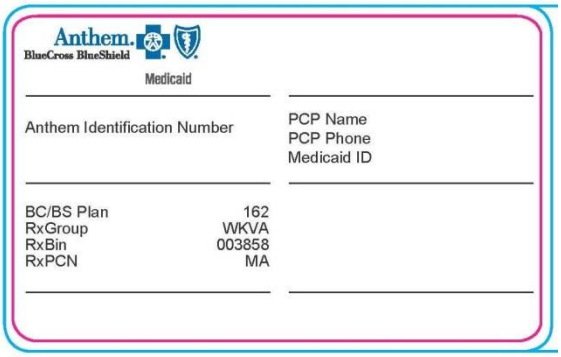
Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

3.02 Member Identification Card

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

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

Sample of the Anthem I.D. Card:



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

3.03 DentaQuest's Eligibility Systems

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

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

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

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

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

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

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

3.04 Appointment Availability/ Appointment Waiting Time

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

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

Emergency appointments within 24 hours of request
Urgent care appointments within 48 hours of request
Routine care appointments within 21 days of request

- **Changes in your practice –** In order for DentaQuest to maintain its records, and to ensure the appropriate members are referred to or can reach you, it is required that you notify us if there are any changes to your practice. Please let us know immediately if any changes occur including:
  - Moves or additional locations
  - Hours of operation
  - Phone/fax number changes
  - Changes to member populations seen
  - Email addresses

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

4.0 Emergency Care Requirements (All Plans)

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

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

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

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

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

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

If the member's primary care dentist responds to the notification, the hospital-based provider and the primary care dentist may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient, in accordance with federal law to determine if the patient is a member of DentaQuest, if emergency services and care are not delayed.

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

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

DentaQuest shall not deny payment for emergency services and care.

5.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office. To get the most current list of Anthem participating hospitals, please call the Anthem customer service line at (855)-690-7784.

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

5.01 Hospital Case Management

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

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

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

5.02 Payment for Non-Covered Services

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

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

A recommended Member Consent Form can be found on the DentaQuest Provider Web Portal.

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

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

- "Prior Authorization" requires that the provider obtain permission to perform the procedure prior to performing the service. "Prior Authorization" requires specific documentation to establish medical necessity or justification for the procedure.

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

The Exhibits for each plan indicate which procedures require Review, which type of Review, and the documentation that the provider will need to submit to support his or her request.
Participating Providers will not be paid if this "documentation" is not provided to DentaQuest.
Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or

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

Utilization management decision making is based on appropriate care and service, and does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization. DentaQuest does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff member supports, or tends to support, denial of benefits.

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

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

DentaQuest utilizes claims submissions and information to collect encounter data.

6.01 Electronic Attachments

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

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

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

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

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

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

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

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

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

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

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

6.04 Electronic Claim Submission via Clearinghouse

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

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

6.05 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA

compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@DentaQuest.com to inquire about this option for electronic claim submission.

6.06 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest Dental in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest Dental you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest Dental through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

6.07 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms (2006 or newer ADA claim form) or other forms approved in advance by DentaQuest.

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

- The paper claim must contain an acceptable provider signature.

- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.

- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

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

6.08 Coordination of Benefits (COB)

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

6.09 Filing Limits

Each provider contract specifies a specific time frame after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing," the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

6.10 Receipt and Audit of Claims

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

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

6.11 Direct Deposit

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

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

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

- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

  - By Fax – 1-262-241-4077

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

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

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

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

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

6.12 Provider Recognition in State Medicaid Program

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

7.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

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

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

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

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

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

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

7.01 HIPAA Companion Guide

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

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

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

A. Definitions:

Complaint**:** A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights,

health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the health plan an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

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

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

B. Complaints/Grievance Staff:

DentaQuest's Complaints/Grievance Coordinator receives Member and Provider and appeals. DentaQuest's Complaints/Grievance Coordinator has office hours from Monday through Friday, 8:00am to 5:30pm CST. The Coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified in writing of the resolution (i.e. Plan, Member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

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

Contact information for each plan is located in the table in Section D below.

C. Provider Appeals:

Contracted providers have a right to file an appeal for denied claims (which include prepayment review process), prior authorizations and/or referral determinations. This can be done by submitting a request for appeal in writing with a narrative and supporting documentation to the DentaQuest Provider Appeals Coordinator via mail or fax. All appeals should be sent to the attention of DentaQuest-Provider Appeals,P.O. Box 2906, Milwaukee, WI 53201-2906.2121, North Corpo Provider Appeals Fax line: (262) 834-3452. Providers can also call (800) 508-6787 from Monday through Friday, 8:00am to 5:30pm to file their complaint and/or appeals.

D. Member Complaints/Grievances/Appeals:

Members can file their complaints, grievances and/or Appeals to:

Member's Plan	Telephone	Mail	Fax
Anthem	(855)690-7784	**Medical Necessity Appeals:** Medical Appeals Anthem Blue Cross and Blue Shield Medicaid P.O. Box 62429 Virginia Beach, VA 23466-2429 **Payment Appeals:**	

		Payment Disputes Anthem Blue Cross and Blue Shield Medicaid P.O. Box 61599 Virginia Beach, VA 23466-1599	

E. Policy and Procedures:

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

9.00 Utilization Management Program (Policies 500 Series)

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

9.01 Community Practice Patterns

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

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

9.02 Evaluation

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

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

9.03 Results

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

9.04 Fraud and Abuse (Policies 700 Series)

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

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

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

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

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

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

10.00 Quality Improvement Program (Policies 200 Series)

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

- Provider credentialing and recredentialing.
- Member satisfaction surveys.
- Provider satisfaction surveys.
- Random Chart Audits.
- Complaint Monitoring and Trending.

- Peer Review Process.
- Utilization Management and practice patterns.
- Initial Site Reviews and Dental Record Reviews.
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

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

11.00 Credentialing (Policies 300 Series)

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

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

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

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

Appeal of Credentialing Committee Recommendations (Policy 300.017)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

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

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 36 months.
Note: The aforementioned policies are available upon request by contacting DentaQuest's Provider Services Department at (800) 508-6787 or via e-mail at denelig.benefits@DentaQuest.com.

11.01 Termination

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

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

12.00 The Patient Record

A. Organization

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

    a. Registration data including a complete health history.
    b. Medical alert predominantly displayed inside chart jacket.
    c. Initial examination data.
    d. Radiographs.
    e. Periodontal and Occlusal status.
    f. Treatment plan/Alternative treatment plan.
    g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.

    a. Health history.
    b. Medical alert.
    c. Examination/Recall data.
    d. Periodontal status.
    e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient, (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

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

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

    a. Patient's first and last name.
    b. Date of birth.
    c. Sex.
    d. Address.
    e. Telephone number.
    f. Name and telephone number of the person to contact in case of emergency.
    g. Information regarding the primary language of the enrollee.
    h. Information related to the member's needs for translation services.

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

    a. Current medical treatment.
    b. Significant past illnesses.
    c. Current medications.

d. Drug allergies.
e. Hematologic disorders.
f. Cardiovascular disorders.
g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.
n. Summary of significant surgical procedures.
o. Treating provider's signature and/or initials must be documented on each date of service.
p. Treating provider's signature and/or initials must contain the profession designation (e.g. DDS, DMD, RDH, CDA).

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

   a. Significant changes in health status.
   b. Current medical treatment.
   c. Current medications.
   d. Dental problems/concerns.
   e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:

   a. Health problems which contraindicate certain types of dental treatment.
   b. Health problems that require precautions or pre-medication prior to dental treatment.
   c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   d. Drug sensitivities.
   e. Infectious diseases that may endanger personnel or other patients.

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

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Occlusal classification.
   f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Dentition charting.

7. Radiographs which are:

    a. Identified by patient name.
    b. Dated.
    c. Designated by patient's left and right side.
    d. Mounted (if intraoral films).

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

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

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

    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

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

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

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

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

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

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

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

    a. Patient examination.
    b. Treatment plan.
    c. Treatment status.

C. **Compliance**

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

13.00 Patient Recall System Requirements

A. **Recall System Requirement**

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

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

- "We missed you when you did not come for your dental appointment on month/date. Regular checkups are needed to keep your teeth healthy."

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

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

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

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

B. **Office Compliance Verification Procedures**

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

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

14.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations

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

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

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

   The Panel recommends an individualized Periapical/Occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

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

4. Adult – Dentulous

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

5. Adult – Edentulous

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

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

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

   a. Child – Primary and Transitional Dentition

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

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

   c. Adult – Dentulous

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

   d. Adult – Edentulous

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

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

   a. Child – Primary Dentition

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

   b. Adolescent

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

   c. Adult – Dentulous

      The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no

clinical caries and are not at an increased risk for the development of caries.

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

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

4. Growth and Development Assessment

   a. Child – Primary Dentition

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

   b. Child – Transitional Dentition

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

   c. Adolescent

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

   d. Adult

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

14.01 Criteria for Radiographs

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

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

Panoramic Radiograph vs. Complete Series (FMX)

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

15.00 Recommended Health Guidelines – Periodic Schedules (Ages 0-18 Years)

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

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

PERIODICITY RECOMMENDATIONS					
Age (1)	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Oral Hygiene Counseling (2)	**Parents/ guardians/ caregivers**	**Parents/ guardians/ caregivers**	**Patient/parents/ guardians/ caregivers**	**Patient/ parents/ caregivers**	**Patient**
Injury, Prevention Counseling (3)	**X**	**X**	**X**	**X**	**X**
Dietary Counseling (4)	**X**	**X**	**X**	**X**	**X**
Counseling for non-nutritive habits (5)	**X**	**X**	**X**	**X**	**X**
Fluoride Supplementation (6,7)	**X**	**X**	**X**	**X**	**X**
Assess oral growth and development (8)	**X**	**X**	**X**	**X**	**X**
Clinical oral exam	**X**	**X**	**X**	**X**	**X**
Prophylaxis and topical fluoride treatment (9)		**X**	**X**	**X**	**X**
Radiographic assessment (10)			**X**	**X**	**X**
Pit and Fissure Sealants			**If indicated on primary molars**	**First permanent molars as soon as possible after eruption**	**Second permanent molars and appropriate premolars as soon as possible after eruption**
Treatment of dental disease	**X**	**X**	**X**	**X**	**X**
Assessment and treatment of developing malocclusion			**X**	**X**	**X**
Substance abuse counseling				**X**	**X**
Assessment and/or removal of third molars					**X**
Referral for regular periodic dental care					**X**
Anticipatory guidance (11)	**X**	**X**	**X**	**X**	**X**

1. **First examination at the eruption of the first tooth and no later than 12 months.**
2. **Initially, responsibility of parent; as child develops jointly with parents, then when indicated, only by child.**
3. **Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing.**
4. **At every appointment discuss role of refined carbohydrates; frequency of snacking.**
5. **At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.**
6. **As per American Academy of Pediatrics/American Dental Association guidelines and the water source.**
7. **Up to at least 16 years.**
8. **By clinical examination.**

9. Especially for children at high risk for caries and periodontal disease.
10. As per AAPD Guideline on Prescribing Dental Radiographs.
11. Appropriate discussion and counseling should be an integral part of each visit for care.

16.00 Clinical Criteria

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

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

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

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

16.01 Criteria for Dental Extractions

Not all procedures require review.

Documentation needed for review procedure:

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

Criteria

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

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

2. Oral Surgeon - Submission of treatment for approval
   a. Non-emergency
      i. Pre-payment review – performs treatment and submits documentation with claim – no guarantee provider will get paid for service – procedure must meet medical necessity guidelines for DentaQuest to pay.
      ii. Prior authorization – submit documentation prior to performing treatment. If DentaQuest approves, provider is guaranteed payment as long as patient is eligible on date of service.
   b. Emergency (treatment necessary within 24 hours) – if want prior approval - fax request to (305) 423-8765. Requests must still include documentation when required.

3. Documentation of medical necessity for oral surgery - evidence of diagnosed pathology or demonstrable need (including ortho), rather than anticipated future pathology.
   a. Pathology
      i. Provider must submit narrative and x-rays or photos describing pathology
      ii. Each tooth must show pathology
      iii. Symptomology or impactions without pathology may not be enough
   b. Demonstrable need
      i. Narrative describing need
      ii. Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)
   c. Extractions in conjunction with approved orthodontic treatment
      i. Provider must submit request for extractions from orthodontist
      ii. Needs to be an approved orthodontic case
      iii. To expedite process, provider may also want to submit orthodontic approval

4. General Approval vs. Denial Guidelines
   a. Probable Approval
      i. Pathology =
         1. Non-restorable Decay
         2. Tooth erupting on an angle and impinging on 2nd molars
         3. Recurrent Pericoronitis
         4. Dentigerous Cyst or other growth
         5. Internal or External Root Resorption
         6. 3rd molar has over-erupted due to lack of opposing tooth contact
      ii. Demonstrable need =
         1. **In conjunction with approved orthodontics** where orthodontist requests the 3rd molars be removed to guarantee the success of the orthodontic case (provide referral from ortho and prior auth approval of ortho if possible)
         2. **Pain with no pathology** – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need
   b. Probable Denial
      i. Impaction or Symptomology =
         1. Impaction with no other pathology
         2. Pain or discomfort with unknown pathology

ii. Other 3rd molars have pathology (if one, two, or three teeth show pathology, DentaQuest will not automatically approve the extraction of the remaining non-pathologic teeth)

5. Denials
   a. If administrative denial (e.g. lack of documentation) - Resubmit according to deficiencies noted in EOB
   b. If clinical denial:
      i. Resubmit with documentation showing additional clinical evidence for extraction
      ii. Advise member services that the service is not covered
         1. Member can appeal following appeal process in member handbook
         2. Provider and member may work out an out-of-pocket arrangement

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

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

16.02 Criteria for Cast Crowns

Documentation needed for review of procedure:

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

Criteria

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

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

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

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

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

Approval for Crowns will not meet criteria if:

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

16.03 Criteria for Endodontics

Not all procedures require review.

Documentation needed for review of procedure:

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

<u>Criteria</u>

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

Root canal therapy must meet the following criteria:

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

Approval for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
- Retreatment of previous root canal therapy is a separate procedure (codes D3346, D3347 and D3348) and is generally not a covered service (check the member's plan for covered services).

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

16.04 Criteria for Stainless Steel Crowns

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

Documentation needed for review of procedure:

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

Criteria

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

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

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

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

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

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

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

16.05 Criteria for Review of Operating Room (OR) Cases

All Operating Room (OR) Cases MUST be reviewed.

Provider must submit the following documents for review via fax to DentaQuest's Short Procedure Unit (SPU) at (262) 834-3575 or via mail to DentaQuest - (or DentaQuest SPU Dept.) P.O. Box 339 Mequon, WI 53092 for review of OR cases:

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

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

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

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

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

Criteria

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

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

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

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

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

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

16.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for review of procedure:

- Treatment plan.

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

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

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

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.

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

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

The replacement teeth should be anatomically full sized teeth.

Approval for removable prosthesis will not meet criteria:

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

Criteria

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

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

16.07 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to review and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Review requirements:

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

16.08 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

16.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for review of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for general anesthesia or IV sedation.

- Treatment rendered under emergency conditions, when review is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by health plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

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

16.10 Criteria for Periodontal Treatment

Documentation needed for review of procedure:

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

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

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

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

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

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

Criteria

- A minimum of four (4) teeth affected in the quadrant for code D4341.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

    1. Radiographic evidence of root surface calculus.
    2. Radiographic evidence of noticeable loss of bone support.
    3. Intra-oral pictures when submitting for codes D4210 and D4211.
    4. Narrative.

16.11 Clinical Criteria for Orthodontics

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

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

- If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. DentaQuest will now require any dentist that submits ortho models to also submit a claim (D8660) for the model in order for payment to be processed if the case is denied.

Orthodontic treatment requires the following documentation to show medical necessity:

- Completed ADA Claim Form
- Study models or OrthoCad equivalent or appropriate photographs
- Lateral cephalometric radiograph, panorex, or PA x-rays
- Narrative or Rationale including diagnosis/treatment plan (On a case by case basis).

Appropriate photographic requirements include:

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

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

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

KENTUCKY ORTHODONTIC CRITERIA FOR MEDICAL NECESSITY	YES	NO
Deep impinging overbite that shows palatal impingement of the majority of lower incisors.		
True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
Demonstrates a large anterior -posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class Ill)		
Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar).		
Significant posterior open bites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion).		
Impacted Incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
Crowding of 7 - 8 mm in either the maxillary or mandibular arch.		
Overjet in excess of 9 mm.		
Dentition exhibits a profound impact from a congenital or developmental disorder.		
Significant facial asymmetry requiring a combination orthodontic and orthographic surgery for correction.		

Orthodontic Codes for Kentucky;

- D8080- Comprehensive treatment
- D8670 - One adjustment is allowed after six months per member; a year and a half of treatment
- D8999- Two D8999s are allowed:

One D8999 is to set up and be allowed for deband and retainers.
Second D8999 is for COC/Transfer cases or by demonstration of medical necessity

- D8660 - Records for denied cases only -1 per Lifetime

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

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

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

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

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

Fax or mail a copy of our Authorization Determination letter with the date of services (banding date) filled in. Our fax number is 262. 241.7150.

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

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

Please notify DentaQuest should the patient discontinue treatment for any reason

Orthodontic Payment Information

- Initial payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, de-banding, 1 set of retainers, and 12 months of retainer adjustments (If retainer fees are not separate).

- Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit a claim for a periodic treatment visits (Code D8670) after six months of treatment to receive the final payment for orthodontics. At the end of treatment, Providers may bill for D8210 or D8220 for retention.

- The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and one (1) periodic orthodontic treatment visits (D8670) six months after banding. Members may not be billed for broken, repaired, or replacement of brackets or wires.

- Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the consultant, this will be applied for all denied cases. Please do not submit separate claims for these procedures.

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

Continuation of Treatment:

- Completed "Orthodontic Continuation of Care Form" - See Appendix A.
- Completed ADA claim form listing services to be rendered.
- A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.
- A Release from the previous provider or a copy of the prior approval from another Medicaid Vendor, whichever one applies.
- If the member is private pay or transferring from a commercial insurance program: Original diagnostic models (or OrthoCad equivalent), radiographs (optional).

If the Member started treatment under commercial insurance or fee for service, we must receive the ORIGINAL diagnostic models (or OrthoCad), or radiographs (optional), banding date, and a detailed payment history.
It is the provider's and patient's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

Continuity of Care Process:

Ortho Continuation/Transfer of Care: Member undergoing orthodontic transfers to from another MCO.
DentaQuest will still need to assess medical necessity for continuation of treatment using established orthodontic COC protocol.

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

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

- Ortho COC Form
- Completed ADA form with treatment plan
- Copy of the member's prior approval letter with the total case fee and payment structure
- Detailed payment history
- Lateral cephalometric radiograph, panorex, or PA x-rays

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

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

COC for Member Transfer:

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

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

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

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

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

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

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

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

17.00 Cultural Competency Program

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

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

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

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

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

18.00 Reimbursement of Services Rendered

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

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

In addition, the services must meet the following criteria:

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

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

20.00 Language and Translation Services

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

Services include:

- TDD/TYY Services for those with a hearing impairment
  - AT&T Relay Service in English: **1-800-855-2880**
  - AT&T Relay Service in Spanish: **1-800-855-2884**
  - AT&T Relay Service for associates contacting hearing impaired members: **1-800-848-0229**

- Video Relay Services
  - Visit **http://www.fcc.gov/encyclopedia/trs-providers** for a list of Video Relay Service Providers.

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

APPENDIX A - Attachments

Additional Resources

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

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

APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

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

Accredited Standards Committee (ASC X12)

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

American Dental Association (ADA)

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

Association for Electronic Health Care Transactions (AFEHCT)

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

Centers for Medicare and Medicaid Services (CMS)

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

Designated Standard Maintenance Organizations (DSMO)

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

Office for Civil Rights (OCR)

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

United States Department of Health and Human Services (DHHS)

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

Washington Publishing Company (WPC)

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

Workgroup for Electronic Data Interchange (WEDI)

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

APPENDIX B

Member's Covered Benefits (See Exhibits)

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

(800) 508-6787, press option 2

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

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

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

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

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

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

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

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

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

IMPORTANT

For procedures where "Review Required" fields indicate "yes".

"Review Required" means either Prior Authorization or Prepayment review. Prepayment review requires that the provider must submit the indicated documentation to show medical necessity.

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

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

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

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

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