DentaQuest, LLC

Smiles For Children

Commonwealth of Virginia Medicaid, FAMIS, FAMIS Plus, Dental Program

Office Reference Manual

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Mequon, WI 53092
888.912.3456
www.dentaquestgov.com

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DentaQuest, LLC
Address and Telephone Numbers

Provider Services
12121 N. Corporate Parkway
Mequon, WI 53092

***Smiles For Children*: 888.912.3456**

Network Development
Fax numbers:
Claims/payment issues: 262.241.7379
Claims to be processed: 262.834.3589
All other: 262.834.3450
Claims questions:
denclaims@dentaquest.com
Eligibility or Benefit Questions:
denelig.benefits@dentaquest.com

Credentialing
12121 N. Corporate Parkway
Mequon, WI 53092
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Customer Service/Member Services
12121 N. Corporate Parkway
Mequon, WI 53092
888.912.3456

TDD (Hearing Impaired)
800.466.7566

Special Needs Member Services
800.660.3397

Fraud Hotline
800.237.9139

DentaQuest's Virginia Office
7400 Beaufont Springs Drive
Suite 300
Richmond, VA 23225
866.853.0657

Prior authorizations for Hospital Operating Room Cases should be sent to:
DentaQuest, LLC-OR Authorizations
P.O. Box 339
Mequon, WI 53092

Authorizations should be sent to:
DentaQuest, LLC–VA Authorizations
12121 N. Corporate Parkway
Mequon, WI 53092

Dental claims should be mailed to:
DentaQuest, LLC-VA Claims
12121 N. Corporate Parkway
Mequon, WI 53092
or e-mailed to:
EDITeam@greatdentalplans.com

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

Provider Appeals should be sent to:
DentaQuest, LLC
Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

Member Grievance and Appeals
888.912.3456
DentaQuest, LLC
Smiles For Children
Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

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DentaQuest

Smiles For Children
Improving Dental Care Across Virginia

SMILES FOR CHILDREN

Statement of Members Rights and Responsibilities

The mission of ***Smiles For Children*** is to expand access to high-quality, compassionate oral health services within the allocated resources. *Smiles For Children* is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. As a member of the ***Smiles For Children*** program, your child has the right to:

- Be treated with respect, dignity, and privacy
- Receive information about ***Smiles For Children*** and the services available
- Be able to choose a dental care provider from the ***Smiles For Children*** directory
- Be able to refuse care from a specific dentist
- Make decisions about your child's dental care
- File a complaint or appeal about a dental care provider or ***Smiles For Children***
- Have access to your child's dental records
- Not be discriminated against by the health care provider on the basis of age, sex, race, color, physical or mental handicap, national origin, ethnicity, religion, sexual orientation, genetic information, economic status, source of payment or type, or degree of illness or condition
- Have your health information kept private pursuant to state and federal laws
- Be told of changes in services or if your dentist leaves ***Smiles For Children*** within (15) calendar days from the date that DentaQuest becomes aware that your dentist will no longer be available to render services.
- Request an interpreter when you call ***Smiles For Children*** Member Services
- Have any printed materials translated into your primary language or to request an alternative format
- Request an interpreter when translation is needed to understand treatment received from a ***Smiles For Children*** dentist.

As a member of the ***Smiles For Children*** program you are responsible for:

- Using the ***Smiles For Children*** dental program
- Knowing, understanding, and following the terms and conditions of this handbook
- Listening to the dentist and following instructions about the care of your child's teeth
- Making and keeping appointments, and being on time for your appointment
- Canceling appointments and scheduled transportation as early as possible
- Showing your child's identification card and any other insurance card every time you go to the dentist
- Making sure you are the only person who uses your identification card and letting your local Department of Social Services or your MCO know if it is lost or stolen
- Answering questions about your child's health that will help your dentist take care of your child
- Letting your dentist know if your child has had care in an emergency room within 24 hours or been to another dentist recently
- Notifying Member Services when you believe someone has purposely misused ***Smiles For Children*** benefits or services.
- Treating the dentist with dignity and respect.
- Immediately informing your local Department of Social Services or the FAMIS CPU of any of these things:
  - An address change each and every time you move
  - A phone number change each and every time you change phone numbers
  - If you have a new baby or have a family size change
  - A name change

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Smiles For Children
Improving Dental Care Across Virginia

Smiles For Children

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 the ***Smiles For Children*** program.

3. File an appeal or complaint pursuant to the procedures of ***Smiles For Children***.

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

5. Object to policies, procedures, or decisions made by ***Smiles For Children.***

6. Charge an eligible ***Smiles For Children*** Member for dental services that are not covered services only if the Member knowingly elects to receive the services as a private-pay patient and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include: services not covered under the ***Smiles For Children*** plan; services for which pre-authorization has been denied and deemed not medically necessary; and services which are provided out-of-network.

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

8. To determine to what extent they will participate in the ***Smiles For Children*** program (i.e. set patient panel size).

Providers have the responsibility to:

1. Protect the patients'/members' rights to privacy.

2. Comply with any applicable Federal and State laws that pertain to members rights and not to discriminate against a member on the basis of age, sex, race, physical or mental handicap, national origin, ethnicity, religion, sexual orientation, genetic information, economic status, source of payment or type, or degree of illness or condition.

3. Notify DentaQuest of any changes in their practice information, including: location, telephone number, limits to participation, providers joining or leaving the practice, etc.

4. Hold the ***Smiles for Children*** Members harmless and shall not bill any Member for services if the services are not covered as a result of any error or omission by Provider.

5. Adhere to the ***Smiles for Children*** Provider Participation Agreement.

* * *

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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.

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1.00 What is *Smiles For Children*?

Smiles For Children is the new dental program for children enrolled in Medicaid, FAMIS or FAMIS Plus. All dental services for Medicaid, FAMIS or FAMIS Plus Members will be provided through ***Smiles For Children***. ***Smiles For Children*** is provided by the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) in collaboration with the Virginia Dental Association (VDA) and the Old Dominion Dental Society (ODDS) and is administered by DentaQuest, LLC on an administrative services only (ASO) basis. This means that DentaQuest will process and pay claims to providers on a fee-for-service basis, based on the ***Smiles For Children*** fee schedule, and DMAS retains responsibility for reimbursement to DentaQuest for the cost of the claim payments made to providers. Reimbursement to providers outside of the ***Smiles For Children*** network is not available.

Smiles For Children provides coverage for Medicaid and FAMIS Plus children under 21 years of age and under age 19 for FAMIS children. Covered services are defined as any medically necessary diagnostic, preventive, restorative, and surgical procedures, as well as orthodontic procedures, administered by, or under the direct supervision of, a dentist. Limited medically necessary oral surgery coverage is available for enrollees 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicare and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health. Reference Exhibits A and B of this manual for detailed coverage criteria and guidelines.

The goals of the ***Smiles For Children*** program are to:

- Increase provider participation in the ***Smiles For Children*** network
- Streamline program administration, making it easier for provider to participate
- Create a partnership between DMAS, DentaQuest and Organized Dentistry
- Improve Member access to quality dental care
- Improve oral health and wellness for Virginia's children

Value-Added Provider Benefits

1.01 Dedicated Call Center for Providers

DentaQuest offers Participating ***Smiles For Children*** Providers access to call center representatives who specialize in areas such as:

- Eligibility, benefits and authorizations,
- Member placements, and
- Claims

You can reach these specialists by calling 888.912.3456.

1.02 Provider Training

DentaQuest offers free Provider training sessions periodically throughout the Commonwealth of Virginia. These sessions include important information such as: claims submission procedures, pre-payment and prior-authorization criteria, how to access DentaQuest's clinical personnel, etc. In addition, Providers can contact the Virginia Provider Relations Representative for assistance, or to request a personal, in-office visit, by calling: 866.853.0657.

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1.03 Provider Newsletters

DentaQuest publishes quarterly Participating Provider newsletters that include helpful information of interest to providers. To request a copy of the DentaQuest provider newsletter, you may call our Virginia Provider Relations Representative at 866.853.0657, or call 888.912.3456.

1.04 DentaQuest Website

DentaQuest's website includes a "For Provider's Only" section, that allows Participating ***Smiles For Children*** Providers access to several helpful options including:

- Member eligibility verification
- Claims submission
- Authorization Submission
- View claim status
- Create claim tracking reports
- Member treatment history

For more information, contact DentaQuest's Systems Operations Department via email at EDITeam@greatdentalplans.com.

1.05 Other Value-Added Provider Benefits

Other value-added provider benefits (detailed in other sections of this manual) include:

- Dedicated Virginia Project Director, Provider Relations Representative, Outreach Coordinator, and Dental Director
- Streamlined Credentialing
- Minimal Prior Authorization Requirements

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2.00 Patient Eligibility Verification Procedures

2.01 *Smiles for Children* Eligibility

Any eligible Medicaid, FAMIS or FAMIS Plus person is eligible for dental benefits under the ***Smiles For Children*** Program. Please note that when calling DMAS to verify member eligibility, members indicated as enrolled ONLY in the Family Planning Waiver Program (Aid Category 80) are not eligible for dental benefits under the ***Smiles for Children*** Program. Dental providers must call DentaQuest to verify member eligibility. Recipients will not receive a separate ***Smiles For Children*** ID card for dental services. Medicaid, FAMIS and FAMIS Plus eligible recipients will receive dental coverage under ***Smiles For Children*** regardless of their MCO enrollment status. Therefore, recipients may use their Commonwealth of Virginia (blue and white) plastic identification card or any of the following MCO cards: Virginia Premier Health Plan, Optima Family Care, CareNet by Southern Health, AMERIGROUP (as of September 1, 2005), Anthem HealthKeepers Plus, Anthem HealthKeepers Plus by Peninsula, and Anthem HealthKeepers Plus by Priority. (*Although dental services have been carved out from the MCO contracts, all MCO ID cards list the 12-digit Medicaid, FAMIS, and FAMIS Plus ID number for eligibility verification purposes.)*

2.02 Pregnant Women Eligibility – Dental Services

Pregnant women in Medicaid and FAMIS MOMS who are 21 years of age and older are eligible to receive dental benefits (excluding Orthodontia) through Virginia's dental program, Smiles For Children (SFC). Dental benefits for pregnant women who are 21 years of age and older will be discontinued at the end of the month following their 60th day postpartum. Covered services are listed in Exhibit C.

Providers are responsible for documenting that members are pregnant and file claims accordingly.

2.03 DentaQuest Eligibility Systems

Participating ***Smiles For Children*** Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Dentist" section of DentaQuest's website at www.dentaquestgov.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet:
DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquestgov.com. Once you have entered the website, click on "Dentist". From there choose 'Virginia" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 888.912.3456. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

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First Time Users:
First time users will have to register by utilizing their 6 digit DentaQuest Location ID, office name and office address. Please refer to your payment remittance or contact DentaQuest's Systems Operations Department via email at EDITeam@greatdentalplans.com to obtain your location ID You may contact DentaQuest's Systems Operations Department staff between 8 AM and 6 PM Monday through Friday. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

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Access to eligibility information via the Interactive Voice Response IVR line:
To access the IVR, simply call DentaQuest's Customer Service department at 888.912.3456 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a ***Smiles For Children*** Member by entering your 6 digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

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

1. Call DentaQuest Customer Service at 888.912.3456.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

Members must be eligible on the date of service for payment to be made. However, please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888.912.3456. They will be able to assist you in utilizing either system.

2.04 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist participating in the ***Smiles For Children*** program without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization if necessary, for services according to Exhibits A and B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Customer Service Department at the telephone number found on page 2 of this manual.

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2.05 Provider Directory

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

It is very important that you notify DentaQuest of any change in your practice information. Please complete the Provider Change Form found on the website, fax it to DentaQuest at 262.241.7366, or call us at 888.912.3456 to report any changes.

2.06 Member Transportation

Transportation may be available for ***Smiles For Children*** Members through their MCO or through DMAS if the member is not enrolled in a MCO. DentaQuest will refer ***Smiles For Children*** Members to the appropriate transportation vendor for assistance. ***Smiles For Children*** Member transportation assistance can be arranged by calling the following numbers:

- Members in Fee For Service, AMERIGROUP, Anthem — 866.386.8331
- Members in CareNet — 800.734.0430
- Members in Optima Family Care — 877.892.3986
- Members in Virginia Premier — 800.727.7536 (Central)
800.828.7989 (Tidewater)
888.338.4579 (Roanoke)

Dental Providers, Medicaid members, facilities, and agencies are encouraged to visit http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx and select "Transportation Contacts." Here you will be able to locate Medicaid Member Transportation Reservation and Ride Assist telephone numbers. Ride Assist is to be contacted to ask questions about your patient's transportation or report complaints. Please refer to the website listed above as they are updated frequently.

2.07 Tips for Reducing Broken Appointments

Broken appointments are a major concern for the Department of Medical Assistance Services, the Virginia Dental Association, the Old Dominion Dental Society, and DentaQuest. We recognize that broken appointments are a costly and unnecessary expense for providers. Our goal is to remove any barriers that prevent dentists from participating in the ***Smiles For Children*** program as well as barriers that prevent our members for utilizing their benefits.

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

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

- Develop a Broken Appointment policy that is for ALL patients.
- Have a contract that patients sign that spells out their rights and responsibilities.
- Confirm appointments after hours when the patient is likely to be home to answer the call.

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- Confirm all appointments, including recall and hygiene appointments, the day before the appointment.
- Consider telling patients they must confirm their own appointment the day before the visit, or their appointment slot will be lost.
- If a patient has a broken appointment history or is a new patient, it is recommended that you attempt to speak directly with the patient for the appointment confirmation.
- Continuing care appointments made for three to six months ahead should be reserved for patients of record with no history of broken appointments.
- Patients with a history of broken appointments or that did not schedule a continuing care appointment, should receive a postcard asking them to call to schedule an appointment.
- Many emergency patients will not keep future appointments if scheduled on the day of emergency treatment. These patients should be called later during the week to schedule follow-up treatment.
- When a procedure needs to be completed at a subsequent appointment, send information home with patients about that next appointment. The information should stress the importance of such a procedure and indicate possible outcomes if it is not completed within the designated timeframe.
- Maintain a list of patients that can be contacted to come in on short notice; this will allow you to fill gaps when late notice cancellations occur.
- Many patients site daytime obligations such as work or childcare as significant contributing factors to missing appointments. Having extended hours on selected days of the week or occasional weekend hours can alleviate this barrier to accessing dental care.

2.08 Broken/Cancelled/Missed Appointment

The Centers for Medicare and Medicaid Services (CMS) prohibit billing Medicaid beneficiaries for broken, missed or cancelled appointments. Medicaid programs are State designed and administered with Federal policy established by CMS. Federal requirements mandate that providers who participate in the Medicaid program must accept the payment of the agency as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. For more information, please refer to 42 USC § 1396a(a)(25)(c) (which is the United States Code) or 42 CFR § 447.15 (which is the United State regulation).

3.00 Authorization for Treatment

3.01 Dental Treatment Requiring Authorization

Under ***Smiles For Children***, the number of services requiring prior authorization or pre-payment review is significantly reduced. Authorization is a utilization tool that requires Participating ***Smiles For Children*** Providers to submit “documentation” associated with certain dental services for a Member. Participating Providers will not be paid if this “documentation” is not furnished to DentaQuest. Participating Providers must hold the Member, DentaQuest, and DMAS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section 14.00). Please review these criteria as well as the Benefits

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covered to understand the decision making process used to determine payment for services rendered.

A. Authorization and documentation submitted before treatment begins. (Prior Authorization) and Documentation submitted with claim (Pre-payment Review).

Services that require prior-authorization should not be started prior to the determination of coverage (approval or denial of the authorization). Treatment requiring prior-authorization started prior to the determination of coverage will be performed at the financial risk of the dental office.

Services that require pre-payment review, but not prior authorization will require proper documentation prior to consideration for payment. The dentist also has the option of requesting prior authorization (instead of pre-payment review) if a ***Smiles For Children*** decision regarding coverage is desired prior to rendering treatment services.

Your submission of "documentation" should include:

1. Radiographs, narrative, or other information where requested (See Exhibit A and B for specifics by code)
2. CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibit A and B) contain a column marked "Authorization Required". A "Yes" in this column indicates that the service listed requires either prior-authorization or documentation submitted with the claim for pre-payment review in order to be considered for reimbursement. The "Documentation Required" column will describe what information is necessary for review, and whether it must be submitted on a prior-authorization basis, or with a claim following treatment for pre-payment review.

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

B. Submitting Authorization Requests and X-Rays

- 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

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or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

3.02 Authorization for Operating Room (OR) Cases

All operating room (OR) cases must be prior-authorized. The Participating ***Smiles For Children*** Provider should submit the prior authorization to DentaQuest. DentaQuest will serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, DMAS and any other required provider. DentaQuest's dental director will review the case for medical necessity, and render an approval or denial of the services. Once DentaQuest has approved the case, DentaQuest will coordinate authorization for non-dental services (example: facility and anesthesia) with DMAS and the MCO as appropriate, within the MCO provider network.

The Participating ***Smiles For Children*** Provider may contact DentaQuest for a list of participating hospitals and facilities.

Please see section 4.08 for information on submitting claims for services performed in a non-dental setting.

3.03 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, and DMAS harmless for the payment of non-Covered Services except as provided in this paragraph. A provider may charge an eligible ***Smiles For Children*** Member for dental services which are not covered services only if the Member knowingly elects to receive the services and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include:

- Services not covered under the ***Smiles For Children*** plan,
- Services for which prior-authorization has been denied and deemed not medically necessary,
- Services which are provided out-of-network

3.04 Electronic Attachments

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A. Fast Attach™

DentaQuest accepts dental radiographs electronically via **FastAttach™** for prior-authorization requests and pre-payment review. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating ***Smiles For Children*** Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

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

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

800.782.5150

B. OrthoCAD™

OrthoCAD™ - DentaQuest accepts orthodontic models electronically via OrthoCAD™ for authorization requests. DentaQuest allows Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. OrthoCAD™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged models and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for OrthoCAD™ go to www.orthocad.com or call OrthoCAD™ at:800.577.8767

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4.00 Claim Submission Procedures (claim filing options)

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

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

4.01 Claim Submission for Pregnant Women

Prepayment review will be conducted on all claims for pregnant women. Appropriate documentation must include: Narrative indicating member is pregnant with estimated date of delivery (must be noted in box 35 of ADA claim form); Narrative demonstrating medical necessity for those services where additional documentation is required for review (i.e. diagnostic x-rays, perio charting).

4.02 Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose 'Virginia" 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 Customer Service Department at 888.912.3456. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

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

4.03 Electronic Authorization Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. To submit pre-authorizations via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose "Virginia" and press go. You will then be able to log in using your password and ID. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry". The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.

4.04 Electronic Claim Submission via Clearinghouse

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. To submit pre-authorizations via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the

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"Dentist" icon. From there choose "Virginia" and press go. You will then be able to log in using your password and ID. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry". The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.
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.

4.05 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@greatdentalplans.com to inquire about this option for electronic claim submission.

4.06 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual (Type 1) NPI. You may also be required to register for a group (Type 2) NPI (or as part of a group) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group (Type 2) and Individual (Type 1) NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Provider Web Portal.

4.07 Paper Claim Submission

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

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

- The paper claim must contain an acceptable provider signature.

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- 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, LLC-Claims
12121 N. Corporate Parkway
Mequon, WI 53092

4.08 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. The Provider may not bill the Member for any difference between DentaQuest's payment and the Provider's billed amount, or request to share in the cost through a co-payment or similar charge. Providers are expected to take reasonable measures to ascertain any third party resource available to the Member and to file a claim with that party.

In accident cases where dental services are needed, the provider may either bill DentaQuest or wait for a settlement from the responsible liable third party. However, all claims for dental services in accident cases must be billed to DentaQuest within 6 months from the date of the service. If the provider decides to wait for the settlement before billing DentaQuest and the wait extends beyond 6 months from the date of the service, DentaQuest can not reimburse the provider if the time limit for filing a claim related to an accident case has expired.

4.09 Filing Limits

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The timely filing requirement for the Smiles For Children program is 180 calendar days from the date of service and receipt of claim. DentaQuest determines whether a claim has been filed timely by comparing the date of service to the receipt date applied to the claim when the claim is received. If the span between these two dates exceeds the time limitation, the claim is considered to have not been filed timely.

Resubmissions: Adjustment Claims and Claims for Reconsideration of Payment

Adjustment claims or claims that are resubmitted for reconsideration of payment are handled as follows:

- If the original claim was processed and paid and an adjustment is requested, the adjustment claim must be submitted and received within 12 months from the date the original claim was paid.
- If the original claim was processed and denied and a reconsideration of the denied claim is requested, the denied claim must be resubmitted and received within 12 months from the date the original claim was denied provided that the claim was not initially denied for timely filing.

Timely Filing and Coordination of Benefits

When a member has other coverage, the timely filing limit begins with the date of payment or denial from the primary carrier.

4.10 Claims Appeals

A provider may appeal any adverse decision DentaQuest has made to deny, reduce, terminate, delay or suspend covered dental services. Provider may appeal in writing to DentaQuest within 30 days from the date of the denial. Upon completion of the DentaQuest appeal process, providers may appeal to the Department of Medical Assistance Services (DMAS). The Grievances and Appeals processes are outlined in Section 6.00.

4.11 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each Participating ***Smiles For Children*** Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department at 888.912.3456 with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Participating ***Smiles For Children*** Provider office receives an “explanation of benefit” report with their remittance. This report includes patient information and the allowable fee for each service rendered.

4.12 Claim Submission and Payment for Operating Room (OR) Cases

Facility and anesthesia services for operating room cases require pre-authorization. Authorization requirements are outlined in Section 3.02.

Claims related to the facility and anesthesia services rendered in a non-dental setting will be handled as follows:

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A. Managed Care Organization (MCO) Members

1. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services should be submitted to and are paid by DentaQuest. In such cases, facility charges should be submitted directly to the MCO.

2. If the dental provider does not perform the anesthesia services for dental services provided in a non-dental setting, the dental services should be submitted to and are paid by DentaQuest. In such cases, both facility and anesthesia charges should be billed directly to the MCO and within the MCO provider network.

B. Fee For Service (FFS) Members

1. For Medicaid/FAMIS Plus and FAMIS eligible individuals who are not enrolled in an MCO on the date of service (served by the FFS program), facility, anesthesia and any required medical providers must participate in the FFS Medicaid program. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services should be submitted to and are paid by DentaQuest. In such cases, facility charges should be submitted directly to DMAS.

2. If the dental provider does not perform the anesthesia services for dental services provided in a non-dental setting, the dental services should be submitted to and are paid by DentaQuest. In such cases, both facility and anesthesia charges should be billed directly to DMAS and within the DMAS provider network.

4.13 Direct Deposit and Electronic Remittance Statements

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

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

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

Via Fax – 262.241.4077

Via Mail –DentaQuest, LLC
12121 North Corporate Parkway
Mequon, WI 53092
ATTN: PDA Department

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

Providers enrolled in the Direct Deposit Program must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, a switch to a different

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bank or any other relevant information. All changes must be submitted via the Direct Deposit Authorization Form (which can be found on the website). Providers should allow 2-3 weeks notice to implement new banking information. **DentaQuest can not be held responsible for delays in funding if Providers do not notify DentaQuest in writing of any banking changes.**

As a condition of acceptance of the Direct Deposit Program, Providers are also 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. Go to www.dentaquestgov.com.
2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
3. Log in using your password and ID.
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

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5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

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

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

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-2007-2008) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-2007-2008 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 888.912.3456 or via e-mail at denelig.benefits@dentaquest.com.

5.01 HIPAA Companion Guide

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

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6.00 Grievances and Appeals

6.01 Provider Grievances and Appeals

Participating ***Smiles For Children*** Providers that disagree with determinations made by the DentaQuest directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. Please complete the Provider Appeals Form, which can be found on the website and follow the instructions on the form. This notice *and* additional support information must be sent to DentaQuest at the address below within 30 days from the date of the original determination to be reconsidered by DentaQuest's Virginia Peer Review Committee.

DentaQuest, LLC
Attention: Utilization Management/Provider Appeals
12121 N. Corporate Parkway
Mequon, WI 53092

All notices received shall be submitted to DentaQuest's Virginia Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider. Upon completion of the DentaQuest appeal process the Participating provider may appeal to the Department of Medical Assistance Services (DMAS). The appeal must be in writing and sent to DMAS within 30 days from the final appeal decision letter from DentaQuest. Appeals to DMAS must be sent to the following address:

Director
Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

6.02 Member Grievances and Appeals

Complaints (Grievances)
Members may submit complaints to DentaQuest telephonically or in writing on any Smiles for Children program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues. Member complaints should be directed to:

DentaQuest, LLC
Smiles For Children
Attention: Complaints and Appeals
12121 N. Corporate Parkway
Mequon, WI 53092
1-888-912-3456

DentaQuest will respond to member complaints immediately if possible but within no more than 30 working days from the date the complaint (grievance) is received.

Member Appeals
Members have the right to appeal any adverse decision DentaQuest has made to deny, reduce, delay or terminate dental services. Members may request assistance with filing an appeal by contacting DentaQuest at 1-888-912-3456. Members may send appeal requests to DentaQuest at the address listed above within 30 days receipt of the adverse

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decision notice. DentaQuest will respond in writing to member appeals within 30 days of the date of receipt, or within 3 days if the condition needs immediate attention.

State of Virginia Fair Hearing Process

Members also have the right to appeal directly to DMAS at the same time, after, or instead of appealing to DentaQuest. Appeal requests to DMAS must be sent in writing and must be sent within 30 days receipt of DentaQuest's adverse decision to:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
(804) 371-8488
Appeal/review requests may also be faxed to:
(804) 371-8491

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 888.912.3456.

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7.00 Utilization Management Program

7.01 Introduction

Under the provisions of federal regulations, the ***Smiles For Children*** Program must provide for continuing review and evaluation of the care and services paid through Medicaid and FAMIS, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. ***Smiles For Children*** conducts periodic utilization reviews on all providers. In addition, ***Smiles For Children*** conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals. Participating providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DentaQuest. Under the ***Smiles For Children*** Participation Agreement the provider also agrees to give access to records and facilities to ***Smiles For Children*** program representatives upon reasonable request. This section provides information on utilization review and control requirement procedures conducted by ***Smiles For Children*** program personnel.

7.02 Community Practice Patterns

In following with the requirements described in Section 7.01 above, 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 use of Federal and State program dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these 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.

DentaQuest will monitor the quality of services delivered under the Provider Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of dental care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by DMAS for the ***Smiles For Children*** program.

7.03 Evaluation

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

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

7.04 Results

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With the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, DentaQuest's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists may be asked to 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. Providers will be required to refund payments if they are found to have billed contrary to law, regulation, or DMAS/DentaQuest policy or failed to maintain adequate documentation to support their claims. DentaQuest reserves the right to utilize extrapolation methodology in the determination of the amount(s) Providers are required to refund. Providers have the right to appeal these review findings in accordance with the procedures described in Section 14.(b) of the ***Smiles For Children*** provider agreement.

7.05 Fraud and Abuse (Policies 700 Series)

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse for the ***Smiles For Children*** 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 Practice Patterns: (Aberrant Utilization) 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.

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8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program. The Quality Improvement Program includes but is not limited to:

- Provider credentialing and recredentialing
- Member satisfaction surveys
- Provider satisfaction surveys
- Random Chart Audits
- Member Grievance Monitoring and Trending
- Peer Review Process
- Utilization Management and practice patterns
- Quarterly Quality Indicator tracking (i.e. member complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's QI Program, is available upon request by contacting DentaQuest's Customer Service department at 888.912.3456 or via e-mail at:

denelig.benefits@dentaquest.com

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9.00 Credentialing (Policies - 300 Series)

DentaQuest in conjunction with DMAS 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 ***Smiles for Children*** Members.

Upon receipt from a potential new provider of a signed Agreement and application for participation in the ***Smiles For Children*** program, DentaQuest will verify the following credentialing criteria:

- National Provider Identifier number
- Current licensure status
- History of State licensing sanctions or reprimands
- Medicare/Medicaid sanction history
- Malpractice claims history

Following successful verification, the Provider will be enrolled as a Participating Provider in the ***Smiles For Children*** program.

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.

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

ATTENTION ORAL SURGEONS:

Oral surgeons who currently submit, or wish to submit medical claims for Fee For Service Medicaid Members using CPT codes on a HCFA 1500 form to DMAS, must be enrolled with DMAS as a medical provider.

Oral surgeons submitting medical claims for Fee For Service Medicaid Members to DMAS, and dental claims to DentaQuest, must be enrolled in both DMAS and DentaQuest.

Please address questions regarding contracting with DMAS for medical claims reimbursement, to the DMAS Enrollment Provider Unit (PEU) at 1.888.829.5373, or visit the DMAS web site at: http://www.dmas.virginia.gov.

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)

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Network providers are recredentialed at least every 36 months as required by DMAS.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service at 888.912.3456 or via e-mail at: denelig.benefits@dentaquest.com

9.01 Reporting Requirements for Exclusion from Federal Programs

Providers and subcontractors who are performing services under the DMAS Agreement ("Subcontractors") are required to report excluded from participation in Federal health care programs.

Providers and Subcontractors can screen managing employees through the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/ , updating DentaQuest, minimally, on a monthly basis. The HHS-OIG website shall be checked on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs.

Providers and Subcontractors are advised to immediately report any exclusion information discovered. DentaQuest also require that Subcontractor(s) it has contracted Network Development out to shall have written policies and procedures outlining provider enrollment and/or credentialing process.

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10.00 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 Occlusion 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.

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.

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f. Cardiovascular disorders.
g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

3. 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 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. Occlusion 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

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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.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation, (tooth #, quadrant etc.).
    e. Signature of the provider who rendered the service.

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

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

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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.

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11.00 Patient Recall System

A. Recall System Recommendation

Each participating DentaQuest Provider office may maintain and document, a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any ***Smiles For Children*** Member that has sought dental treatment.

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

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

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

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

B. DentaQuest Appointment Assistance

DentaQuest's Customer Service Department uses technology to link ***Smiles For Children*** Members to the closest and most appropriate dental provider. On occasion, Members require special assistance making appointments due to geographic or special physical needs. DentaQuest's Customer Service department includes Member Placement Specialists, responsible for locating providers for Members in emergency or difficult situations. These Member Placement Specialists will assist Members with making appointments with a Participating Provider. DentaQuest will also place reminder phone calls prior to the appointment, to any Member for which DentaQuest's Member Placement Specialist has assisted in scheduling the appointment.

C. Non-Compliant Members

DentaQuest will proactively educate Members on the importance of keeping appointments through various outreach and educational materials, including member newsletters, member handbook, and outreach. DentaQuest will contact and educate ***Smiles For Children*** Members who have been identified by providers as non-compliant.

Providers and dental offices are not allowed to charge members for missed appointments.

D. Office Compliance Verification Procedures

- Participating ***Smiles For Children*** Dentists are expected to meet minimum standards with regards to appointment availability. The standards are:
    - Emergency care – As quickly as the situation warrants
    - Urgent care – Within 48 hours
    - Routine care – Not to exceed 6 weeks

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12.00 Member Communication

A. Effective Communication

DentaQuest expects that participating ***Smiles For Children*** dentists will provide contracted services without discrimination to Medicaid enrollees with special needs. This includes providing or arranging for communication assistance, such as interpreter services, for persons with communication and language barriers.

B. Reimbursement for Professional Interpreter Services

Title XIX of the Social Security Act requires Medicaid providers to provide nondiscriminatory services to its clients including those with limited English proficiency. In order to help providers with this requirement, DMAS has implemented a provision for reimbursement of interpreter services under the ***SFC*** program when there is a need and it relates to the treatment. DMAS maintains an Interpreter Resource list located at ***http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx.*** To access the resource list, select ***Smiles For Children*** Provider Information and go to Interpreter Service Information. Select the resource list. If you do not have an interpreter resource, you may select one from the Interpreter Resource List.

In order for the ***SFC*** dentist to be reimbursed for interpreter services performed at the dental office, the provider must submit the ***SFC*** **Professional Interpreter Service Invoice Form** documenting the services provided by and paid to an interpreter that is proficient in the specific language and that holds a Virginia business license allowing a fee for their service.

Along with the ***SFC*** **Professional Interpreter Service Invoice Form**, providers must submit a copy of the paid invoice/receipt to DentaQuest to include the following information:

- Date and Time of Interpreter service (including beginning and ending time).
- Patient Name and Medicaid ID number
- Interpreter name, address, telephone number, language used, duration of service and interpreter's charge for the service.
- If the interpreter is not listed on the DMAS Interpreter Resource list, the provider must attach a copy of the professional interpreter's business license with the invoice.
- The patient's chart must document that the patient needed and received interpreter services on a specific date. If ongoing interpreter services are required, the provider must include an annual assessment and attestation in the patient's chart confirming need. Payment for that service acknowledges DentaQuest's ability to audit the use of the service at any time.

To be eligible for reimbursement, services must be rendered in conjunction with an eligible ***SFC*** dental service and the claim for these services must be reflected in DentaQuest's claim system. Charges incurred for a missed or broken appointment are not eligible for reimbursement. The ***SFC*** Professional Interpreter Invoice Form must be completed and submitted to DentaQuest within 180 days from the date the interpreter service is utilized.

Mail the ***SFC*** **Professional Interpreter Service Invoice Form** (which can be found on the DMAS and DentaQuest websites) along with the above documentation to:

DentaQuest
Interpreter Services
ATTENTION: Kristen Gilliam
7400 Beaufont Springs Drive

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Suite 300
Richmond, VA 23225

Provider reimbursement will be processed by DentaQuest within 30 days of receipt. ***SFC*** provider should include the address to receive payment. Go to ***http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx.*** Select ***Smiles For Children*** Provider Information and go to Interpreter Service Information for additional guidance.

13.00 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 Panel (the Panel). 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

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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 consisted 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

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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.

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b. Child – Transitional Dentition

The Panel recommended 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 recommended that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a Panoramic Radiograph.

d. Adult

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

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14.00 Health Guidelines – Ages 0-18 Years

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

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2007)
Periodicity and Anticipatory Guidance Recommendations

PERIODICITY RECOMMENDATIONS					
Age	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Clinical oral exam (1,2)	X	X	X	X	X
Assess oral growth and development (3)	X	X	X	X	X
Caries-risk assessment (4)	X	X	X	X	X
Radiographic assessment (5)	X	X	X	X	X
Prophylaxis and topical fluoride treatment (4,5)	X	X	X	X	X
Fluoride Supplementation (6,7)	X	X	X	X	X
Anticipatory guidance/counseling (8)	X	X	X	X	X
Oral Hygiene Counseling (9)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient/ parents/ caregivers	Patient
Dietary Counseling (10)	X	X	X	X	X
Injury, Prevention Counseling (11)	X	X	X	X	X
Counseling for non-nutritive habits (12)	X	X	X	X	X
Counseling for speech/language development	X	X	X	X	X
Substance abuse counseling					X
Counseling for intraoral/perioral piercing					X
Assessment and treatment of developing malocclusion			X	X	X
Assessment for pit and fissure sealants (13)			X	X	X
Assessment and/or removal of third molars					X
Transition to adult dental care					X

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries.
3. By clinical examination.
4. Must be repeated regularly and frequently to maximize effectiveness.
5. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6. Consider when systemic fluoride exposure is suboptimal.
7. Up to at least 16 years.
8. Appropriate discussion and counseling should be an integral part of each visit for care.
9. Initially, responsibility of parent: as child develops, jointly with parent; then, when indicated, only child.
10. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouthguards.
12. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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15.00 Clinical Criteria

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

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

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

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

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

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

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

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

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

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these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to ***Smiles For Children*** Members and we appreciate your participation in the program.

15.01 Criteria for Dental Extractions

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals or panorex.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

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

15.02 Criteria for Cast Crowns

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

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Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals or panorex.

Criteria

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

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

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

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

- 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.

Payment for Crowns will not meet criteria if:

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

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15.03 Criteria for Endodontics

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Sufficient and appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex.

Criteria

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

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Payment for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Root canal therapy is for third molars, unless they are an abutment for a partial denture.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

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

Other Considerations

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

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

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15.04 Criteria for Stainless Steel Crowns

Authorization or pre-payment review is not required.

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.

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

- 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% supported in bone.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Treatment using Stainless Steel Crowns will not meet criteria if:

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

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15.05 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.

Please mail requests for OR authorization to:

DentaQuest, LLC-OR Authorizations
P.O. Box 339
Mequon, WI 53092

All Operating Room (OR) Cases Must be Authorized.

The Participating ***Smiles For Children*** Provider should submit the prior authorization. DentaQuest will serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, DMAS and any other required provider. DentaQuest's dental director will review the case for medical necessity, and render an approval or denial of the services. Once DentaQuest has approved the case, DentaQuest will coordinate authorization for non-dental services (example: facility and anesthesia) with DMAS and the MCO as appropriate, within the MCO provider network.

Criteria

In most cases, OR will be authorized (for procedures covered by ***Smiles For Children***) if the following is (are) involved:

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

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15.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth: bitewings, periapicals or panorex.

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer 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.
- In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

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).

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- 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 that time has elapsed:
    - 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.
    - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
    - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

15.07 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.

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- 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.

15.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Authorization or pre-payment review is not required.

Criteria

General anesthesia or IV sedation may be performed in conjunction with procedures covered by the ***Smiles For Children*** program if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

15.09 Criteria for Periodontal Treatment

Some procedures require pre-payment review documentation. Please refer to the benefit tables for specific information needed by code.

Documentation needed for procedure:

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

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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."

Criteria

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

  1) Radiographic evidence of root surface calculus.
  2) Radiographic evidence of noticeable loss of bone support.

16.00 Orthodontia Documentation

DentaQuest has always required the submission of plaster models, along with other required documentation such as x-rays, to review and approve treatment necessity for an orthodontic case. DentaQuest will now accept a complete series of intra-oral photographs instead of the plaster models. All other previously required documentation, including panoramic and cepholometric films, tracings, score sheets, and narratives; will also need to be submitted with the photographs. This change will reduce postage costs for providers, increase the speed with which records are returned, and eliminate the possibility of models being damaged in transit. If your office is unable to submit intra-oral photos, plaster models will still be accepted.

The photographs must be of good clinical quality and should 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 to evaluate overjet. Please note:** *This photo is only necessary when there is a significant overjet that will affect the results of the review.*
- **Right buccal view, in occlusion**
- **Left buccal view, in occlusion**

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- **Maxillary Occlusal view**
- **Mandibular Occlusal view**

Orthodontic treatment requests, must include photographs, or models and all pertinent measurement information including overjet. All other required documentation, including panoramic and cepholometric x-rays, tracings, narratives, and scoring forms are still required for review.

If your office currently submits digital models through OrthoCad, these will continue to be accepted. OrthoCAD case submissions do not require models or photographs.

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APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

A. "Agreement" means the contract between DentaQuest acting on behalf of the ***Smiles For Children*** program and Provider.

B. "Covered Services" means a dental health care service or supply, including those services covered through the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program that satisfies all of the following criteria:

- Is medically necessary;
- Is covered under the ***Smiles For Children*** program;
- Is provided to an enrolled member by a Participating Provider
- Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.

C. "DMAS" means the Virginia Department of Medical Assistance Services.

D. "DentaQuest" shall refer to DentaQuest, LLC

E. "DentaQuest Service Area" shall be defined as the Commonwealth of Virginia.

F. "Emergency Services" means covered dental services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

G. "EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment program for persons (under age 21) made pursuant to 42 U.S.C. Sections 1396a(a)43, 1396d(a) and (r) and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.

H. "Medically Necessary" means covered medical, dental, behavioral, rehabilitative or other health care services which:

- are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability:
- are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions;
- are consistent with the diagnoses of the conditions;
- are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence; and
- will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

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I. "Member or Enrollee" means any individual who is eligible to receive Covered Services provided for under the ***Smiles For Children*** program.

J. "Participating Provider or Provider" is a dental professional or facility, including a Provider Dentist, that has a written participation agreement in effect with DMAS and DentaQuest, to provide dental services to Members of the ***Smiles For Children*** program.

K. "Claim" means any bill or claim made by or on behalf of an enrollee or the Dentist to DentaQuest under the agreement for payment for Dental Services under the ***Smiles For Children*** program.

L. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim form a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

M. "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.

N. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the laws of the Commonwealth of Virginia, who practices as a shareholder, partner, or employee of Provider.

O. "***Smiles For Children***" is the name of the dental program provided to Virginia Medicaid, FAMIS and FAMIS Plus enrollees, administered by DentaQuest, under the direction of DMAS.

P. "FAMIS" is the DMAS program for members under the age of 19 who are eligible to receive services under the State Child Health Insurance Plan under Title XXI, as amended.

Q. "FAMIS Plus" is the DMAS program for members under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90;90 (under 6 years of age);92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities.

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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 @ www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Orthodontic Criteria Index Form
- Malocclusion Severity Assessment
- Malocclusion Severity Assessment Instructions
- Orthodontic Continuation of Care Form
- OrthoCAD Submission Form
- Orthodontic Pre-Authorization Checklist
- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam
- Recall Examination Form
- Authorization for Dental Treatment
- Medical and Dental History
- Provider Change Form
- SFC Transportation Complaint Form
- Professional Interpreter Service Invoice Form
- Provider Appeal Form
- Authorization to Honor Direct Automated Clearinghouse (ACH) Credits Disbursed by DentaQuest Services of Virginia, LLC
- ANSI Companion Guide

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 888.912.3456

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APPENDIX B

Covered Benefits (See Exhibits A and B)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for ***Smiles for Children*** members under age 21. There is a very limited adult dental benefit for the ***Smiles for Children*** members 21 and over, which is administered by DentaQuest and described in Exhibit B. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:**

888.912.3456

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.**

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

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

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

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

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

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Exhibit A Benefits Covered for
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Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 12 Month(s) Per Provider OR Location. Limited examinations D0140 are not reimbursable on the same day as codes D0120, D0145, D0150 and D9310.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	One of (D0145) per 6 Month(s) Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 6 Month(s) Per Provider OR Location. One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210, D0330) per 60 Month(s) Per Provider OR Location. Frequency of service or age deviation must be supported by Medical Necessity.	
D0220	intraoral - periapical first radiographic image	0-20		No		
D0230	intraoral - periapical each additional radiographic image	0-20		No		

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Exhibit A Benefits Covered for
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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-20		No	Two of (D0240) per 12 Month(s) Per patient.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No		
D0251	extra-oral posterior dental radiographic image	0-20		No		
D0270	bitewing - single radiographic image	0-20		No		
D0272	bitewings - two radiographic images	0-20		No	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.	
D0273	bitewings - three radiographic images	0-20		No	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.	
D0274	bitewings - four radiographic images	0-20		No	One of (D0272, D0273, D0274) per 12 Month(s) Per Provider OR Location.	
D0330	panoramic radiographic image	6 - 20		No	One of (D0210, D0330) per 60 Month(s) Per Provider OR Location. Frequency of service or age deviation must be supported by Medical Necessity.	
D0340	cephalometric radiographic image	0-20		No	Non-orthodontic procedures.	
D0470	diagnostic casts	0-20		No	Non-orthodontic procedures.	

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Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars once per tooth, per lifetime.

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

The application of topical fluoride treatment is allowed for Members up to age 21 once every 6 months when provided in conjunction with a prophylaxis. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13-20		No	One of (D1110, D1120) per 6 Month(s) Per Provider OR Location. Includes minor scaling procedures.	
D1120	prophylaxis - child	0-12		No	One of (D1110, D1120) per 6 Month(s) Per Provider OR Location.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1203, D1204, D1206, D1208) per 6 Month(s) Per Provider OR Location.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1203, D1204, D1206, D1208) per 6 Month(s) Per Provider OR Location.	
D1351	sealant - per tooth	5-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1354) per 1 Lifetime Per patient per tooth for First and Second Molars. Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.	
D1354	interim caries arresting medicament application	5-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1354) per 1 Lifetime Per patient per tooth for First and Second Molars.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	
D1515	space maintainer - fixed - bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515, D1525) per 24 Month(s) Per patient per arch.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant.	

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Exhibit A Benefits Covered for
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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515, D1525) per 24 Month(s) Per patient per arch.	
D1550	re-cement or re-bond space maintainer	0-20		No		
D1555	removal of fixed space maintainer	0-20		No	Not allowed by dentist or dental office that placed space maintainers.	

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Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months, unless there is recurrent decay or material failure. Payment will be made for only one single surface restoration per tooth surface. For example, two separate occlusal (O) restorations on the same tooth are to be billed as one occlusal restoration. However, for example it is permissible to bill for multiple, but separate restorations involving the same tooth surface, such as a mesial-facial (MF) and a distal-facial (DF) restoration on the same anterior tooth.

The acid etching procedure is considered part of the restoration and is not billed as a separate procedure.

Local anesthetic is included in the restorative service or surgical fee and is not separately reimbursed.

A sedative restoration is considered a temporary restoration only and not a base under a restoration.

Bases, copalite, or calcium hydroxide liners placed under a restoration are considered part of the restorations and are not billable as separate procedures.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed.

Only full labial veneers porcelain (lab) are a covered service.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for VA Smiles for Children - Under 21

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2644	onlay-porcelain/ceramic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2644) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit A Benefits Covered for
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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2710	crown - resin-based composite (indirect)	0-20	Teeth 1 - 32	Yes	One of (D2710) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2720	crown-resin with high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2721	crown - resin with predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic substrate	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)

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Exhibit A Benefits Covered for VA Smiles for Children - Under 21

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2794	crown - titanium	0-20	Teeth 1 - 32	Yes	One of (D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No		
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No		
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth A - T	No		
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No		
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	No		

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No		
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth C - H, M - R	No		
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No		
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy, or on the same date of service as a restoration.	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No		
D2952	cast post and core in addition to crown	0-20	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth. One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 1 Day(s) Per patient per tooth. One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	
D2962	labial veneer (porc laminate) - laboratory	0-20	Teeth 1 - 32	Yes	One of (D2962) per 60 Month(s) Per patient per tooth. Will be considered as an alternative to a full restoration for an endodontically treated tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)

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Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.
The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

For all services that require pre-payment review, Providers have the option of requesting prior authorization

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (exluding final restoration)	0-20	Teeth 1 - 32	No		
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No		
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320, D3330).	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No		
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	No		
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth A, B, I - L, S, T	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D3347	retreatment of previous root canal therapy-bicuspid	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per Provider per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	No		
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	No	Limited three (3) treatments.	
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	No	One of (D3353) per 1 Lifetime Per Provider per tooth.	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D3421	apicoectomy - bicuspid (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D3430	retrograde filling - per root	0-20	Teeth 1 - 32	Yes	One of (D3430) per 1 Lifetime Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)

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For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210) per 24 Month(s) Per patient per quadrant. One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A min of 4 affected teeth in the quadrant. Gingivectomies for the removal of hyperplasic tissue to reduce pocket depth. Request only when non-surgical treatment has not been effective or when the patient is taking medications that cause such conditions.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4211) per 24 Month(s) Per patient per quadrant. One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. 1 to 3 affected teeth in the quadrant. For removal of hyperplastic tissue. Should be only requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications that result in such conditions.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Periodontal charting and preoperative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 60 Month(s) Per patient per quadrant. One of (D4260, D4261) per 60 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4261) per 60 Month(s) Per patient per quadrant. One of (D4260, D4261) per 60 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes	Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes	Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	No		
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	No		
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32	No	One of (D4277) per 1 Lifetime Per patient per quadrant.	
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	No	One of (D4278) per 1 Lifetime Per patient per quadrant.	
D4320	provision splinting - intracoronal	0-20	Per Arch (01, 02, LA, UA)	No		
D4321	provision splinting - extracoronal	0-20	Per Arch (01, 02, LA, UA)	No		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. A minimum of four (4) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Check service limit. Periodontal charting and pre-operative radiographs with claim for pre-payment review.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	0-20		No	One of (D4355) per 12 Month(s) Per patient. Only covered when there is substantial gingival inflammation (gingivitis) in all four quadrants. Cannot be billed on same day with D1110 or D1120.	

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4910	periodontal maintenance procedures	0-20		No	Four of (D4910) per 12 Month(s) Per patient. Any combination of D1110, D1120 and D4910 up to four (4) per 12 months. Covered following active treatment only (D4210, D4211, D4260, D4261, D4341, D4342).	

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Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member.

Authorization for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. For partial dentures, two or more posterior teeth must be missing in a quadrant or at least one posterior tooth in each quadrant of the same arch.

Authorization for cast partial dentures for anterior teeth generally will not be given unless two or more anterior teeth in the same arch are missing. A modified space maintainer is to be considered when only one anterior tooth is missing in an arch, Exceptions may be made on a per case basis.

Dentures will not be preauthorized when:

Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of the patient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

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

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	No	One of (D5110) per 60 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	No	One of (D5120) per 60 Month(s) Per patient.	
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	No	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	No	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		Yes	One of (D5211, D5213, D5221, D5223, D5225) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	0-20		Yes	One of (D5212, D5214, D5222, D5224, D5226) per 60 Month(s) Per patient. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D5281	removable unilateral partial denture - one piece cast metal	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D5281) per 60 Month(s) Per patient per quadrant. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5410	adjust complete denture - maxillary	0-20		No	Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	0-20		No	Not covered within 6 months of placement.	
D5421	adjust partial denture-maxillary	0-20		No	Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	0-20		No	Not covered within 6 months of placement.	
D5510	repair broken complete denture base	0-20	Per Arch (01, 02, LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5610	repair resin denture base	0-20	Per Arch (01, 02, LA, UA)	No		
D5620	repair cast framework	0-20	Per Arch (01, 02, LA, UA)	No		
D5630	repair or replace broken clasp	0-20		No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20		No		
D5730	reline complete maxillary denture (chairside)	0-20		No	One of (D5730) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5731	reline complete mandibular denture (chairside)	0-20		No	One of (D5731) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5740	reline maxillary partial denture (chairside)	0-20		No	One of (D5740) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5741	reline mandibular partial denture (chairside)	0-20		No	One of (D5741) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 24 Month(s) Per patient. Not covered within 6 months of placement.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 24 Month(s) Per patient. Not covered within 6 months of placement.	
D5850	tissue conditioning, maxillary	0-20		No		
D5851	tissue conditioning,mandibular	0-20		Yes	Narrative of medical necessity with claim for prepayment review.	narrative of medical necessity

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Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5951	feeding aid	0-20		No		

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Fixed prosthetics will only be covered under special circumstances when no other acceptable less expensive dental service will adequately accomplish the treatment objectives.

Acid etch bonded bridges should be considered as less expensive alternate treatment if circumstances permit. Candidates for fixed prosthetics must have demonstrated very good to excellent oral hygiene and dental health awareness.

A fixed prosthetic will generally only be approved when it replaces a maximum of 2 missing anterior teeth or 1 posterior tooth. Exceptions can be made on a per case basis.

BILLING AND REIMBURSEMENT FOR CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETIC SHALL BE BASED UPON THE CEMENTATION DATE.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6205	pontic - indirect resin based composite	0-20	Teeth 1 - 32	Yes	One of (D6205) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6211	pontic-cast base metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6212	pontic - cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6214	pontic - titanium	0-20	Teeth 1 - 32	Yes	One of (D6214) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6240	pontic-porcelain fused-high noble	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6241	pontic-porcelain fused metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D6245) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6250	pontic-resin with high noble metal	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6251	pontic-resin with base metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6252	pontic-resin with noble metal	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6545	retainer - cast metal fixed	0-20	Teeth 1 - 32	Yes	One of (D6545) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-20	Teeth 1 - 32	Yes	One of (D6548) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6710	crown - indirect resin based composite	0-20	Teeth 1 - 32	Yes	One of (D6710) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6720	crown-resin with high noble metal	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6721	crown-resin with base metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6722	crown-resin with noble metal	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6740	prosthodontics fixed, crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6750	crown-porcelain fused high noble	0-20	Teeth 1 - 32	Yes	One of (D6750) per 60 Month(s) Per patient per tooth. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6751	crown-porcelain fused to metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6752	crown-porcelain fused noble metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6790	crown-full cast high noble	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6791	crown - full cast base metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6794	crown - titanium	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs of all teeth in arch with claim for pre-payment review.	pre-operative x-ray(s)
D6930	re-cement or re-bond fixed partial denture	0-20		No		

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Exhibit A Benefits Covered for
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Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit A may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - deciduous tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Removal of asymptomatic tooth not covered.	
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Removal of asymptomatic tooth not covered.	
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Removal of asymptomatic tooth not covered.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction. Pre-operative radiographs with claim for pre-payment review.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Will not be paid to the dentist or dental group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7260	oroantral fistula closure	0-20		No		
D7261	primary closure of a sinus perforation	0-20		No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review.	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	Pre-operative radiographs and narrative with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	0-20	Teeth 1 - 32	No		
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	Will not be payable unless orthodontic treatment has been proposed or is in progress. Orthodontic approval is not required. Pre-operative radiographs and narrative with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		No		
D7286	incisional biopsy of oral tissue-soft	0-20		No		
D7288	brush biopsy - transepithelial sample collection	0-20		No		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed in edentulous area.	
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed on edentulous area.	
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	No		
D7472	removal of torus palatinus	0-20		No		
D7473	removal of torus mandibularis	0-20		No		
D7485	surgical reduction of osseous tuberosity	0-20		No		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Either D7510 or D7511.	
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		No	One of (D7510, D7511) per 1 Day(s) Per patient. Either D7510 or D7511.	
D7880	occlusal orthotic device, by report	0-20		No	Covered only for temporomandbular pain, dysfunction or assoc. musculature.	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	0-20		No	One of (D7960, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility, for large diastemas between teeth, or when frenum interferes with a prosthetic appliance, or when it is the etiology of periodontal tissue disease. Midsagittal removal only.	
D7963	frenuloplasty	0-20		No	One of (D7960, D7963) per 1 Lifetime Per patient. Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.	
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	No		
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	No		
D7972	surgical reduction of fibrous tuberosity	0-20		No		

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Exhibit A Benefits Covered for
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Medicaid 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.

Limited tooth guidance, if a covered benefit, will be authorized on a selective basis to help prevent the future necessity for full-banded treatment. All appliance adjustments are incidental and included in the allowance for the tooth guidance appliance. With the exception of situations involving gingival stripping or other nonreversible damage, appliances for minor tooth guidance (codes D8020 through D8040) will be approved when they are the only treatment necessary. If treatment is not definitive, the movement will only be covered as part of a comprehensive orthodontic treatment plan.

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

In evaluating requests for orthodontic coverage, medical necessity/handicapping criteria (which can be found on the website) are used as the first level review to determine coverage as applied to the permanent dentition. If the requested orthodontic treatment meets one of the listed criteria, DentaQuest will approve the request for coverage as meeting medically necessary handicapping criteria. Please note, a complete series of intra-oral photographs and all required documentation to support medical necessity should be submitted along with the Orthodontic Criteria Index Form. If the request does not meet any of the listed criteria, then DentaQuest will proceed in evaluating the request by applying the Salzmann Malocclusion Severity Assessment (which can be found on the website).

The Salzmann Evaluation Criteria Index Form is also used as the basis for determining whether a Member qualifies for orthodontic treatment. A member must score a minimum of 25 points to qualify for coverage – points are not awarded for esthetics, therefore additional points for handicapping esthetics will not be considered as part of the determination.

For cases that may not meet the Salzmann criteria, medical necessity documentation to support any of the following impaired functions must be submitted along with all other required documentation, including intra-oral photos or models, panoramic and cepholometric films, tracings, score sheets, and narratives:

* Speech disorder – Documented by a physician or speech therapist,
* Eating disorder – Problems documented by a physician,
* Emotional mental distress to impair school participation – Documented by a teacher, a counselor, or a School psychologist

All documentation will be reviewed together and an appropriate determination made.

Diagnostic study models (trimmed) with waxbites or OrthoCad electronic equivalent, and treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Providers cannot bill prior to services being performed.

If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. In order to receive payment of records for cases that are denied, a claim must be submitted on an ADA form for D8660. The date of service will be the date the treatment plan, radiographs and/or photos, records and diagnostic models were performed by the provider.

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In cases where the member has been approved for comprehensive Orthodontic benefits, and the parent has decided they do not wish to have the child begin treatment at this time or any time in the near future, the proivder may bill for their records, to include the treatment plan, radiographs, models, photos, etc. using D8999 and explaining the situation on the claim for payment. The reimbursement for these records is the same.

General Billing Information for Orthodontics:

The start and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Member's mouth. The Member must be eligible on this date of service.

If a member becomes ineligible during treatment and before full payment is made, DentaQuest will pay the balance of any remaining treatment up to the approved case rate. To receive the remaining balance for members that are ineligible but remain in treatment, providers must submit the claim using D8999 with the last service date the patient was eligible.

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:
Electronically file, fax or mail a copy of the completed ADA form with the date of service (banding date) filled in. Our fax number is 262. 241.7150.

Initial payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, 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 claims for 3 quarterly payments (Code D8670). The member must be eligible on the date of the claim.

The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 3 quarterly periodic billed orthodontic treatments (D8670).

Members may not be billed for broken, repaired, or replacement of brackets or wires. Payment for up to one set of lost/unrepairable retainers may be considered on a medically necessary basis.

In order to receive payment of records for cases that are denied, a claim must be submitted on an ADA form for D8660. The date of service will be the date the treatment plan, radiographs and/or photos, records and diagnostic models were performed by the provider.

Please notify DentaQuest should the Member discontinue treatment for any reason

Continuation of Treatment:

DentaQuest, LLC requires the following information for possible payment of continuation of care cases:

* 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.
* If the member is private pay or transferring from a commercial insurance program: Original diagnostic models (or OrthoCad equivalent), radiographs (optional).

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8020	limited orthodontic treatment of the transitional dentition	0-20		Yes		narrative of medical necessity
D8030	limited orthodontic treatment of the adolescent dentition	0-20		Yes	Narrative of medical need with claim for prepayment review.	narrative of medical necessity
D8040	limited orthodontic treatment of the adult dentition	0-20		Yes	Narrative of medical need with claim for prepayment review.	narrative of medical necessity
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient. Panoramic or periapical radiogprahs. Cephalogram and/or photos or OrthoCad equivalent. PRIOR AUTHORIZATION IS REQUIRED.	Panoramic x-ray, Study model
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		No		
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		No	One of (D8220) per 1 Lifetime Per patient.	
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	For denied cases only An internal authorization will be issued for the payment of the pre-orthodontic visit (code D8660)	
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 90 Day(s) Per patient. Maximum of three (3) quarterly payments.	
D8692	replacement of lost or broken retainer	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D8692) per 1 Day(s) Per Provider OR Location per arch. Narrative of medical necessity with claim for prepayment review.	narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	0-20		Yes	Debanding by dentist other than dentist who initially banded case is one example. Narrative of medical need with claim for prepayment review.	narrative of medical necessity

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Use of IV sedation and general anesthesia will be reviewed on a periodic basis. The service is not routinely used for the apprehensive dental patient. Medical necessity must be demonstrated. Use of nitrous oxide and conscious sedation will also be reviewed on a periodic basis, and patient medical records must include documentation of medical necessity.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Qualified Dental network providers are the only providers who can submit claims for general anesthesia/deep sedation or intravenous conscious sedation services and be paid by DentaQuest. For the claim to be paid the service must be delivered by that same provider. A dental provider not qualified to deliver general anesthesia/deep sedation or intravenous conscious sedation procuring this service from a general anesthesiologist, can not submit a dental claim for that service.

Use procedure code D9999 for all services connected with same day surgery. This includes the initial hospital care, history examination, initiation of diagnostic and treatment programs, prepartion of hospital records, consults with anesthesia and/or pediatrician and others, day surgery visit, and hospital discharge day management including the discharge summary.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	Not allowed with any other services other than radiographs and emergency exam.	
D9223	deep sedation/general anesthesia – each 15 minute increment	0-20		No	Maximum of 180 minutes (12 units).	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment.	
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	0-20		No	Maximum of 180 minutes (12 units).	
D9248	non-intravenous moderate (conscious) sedation	0-20		No	Must be documented as a medically necessity in the patient records.	

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No	One of (D9310) per 1 Day(s) Per Provider OR Location. Not to be billed on the same day or within 6 months of another exam code. Oral evaluations and any consulting services are inclusive in the code. Not to be billed with any other treatment codes, except may be billed with diagnostic codes. Must be a consult request from a health care provider, excludes placement from DentaQuest.	
D9420	hospital or ambulatory surgical center call	0-20		No	Maximum of three (3) for the same day. Cannot be billed with D9999 for hospital care on the same date of service.	
D9440	office visit - after regularly scheduled hours	0-20		No		
D9610	therapeutic drug injection, by report	0-20		No	Either D9610 or D9612.	
D9612	therapeutic drug injection - 2 or more medications by report	0-20		No	Either D9610 or D9612.	
D9630	other drugs and/or medicaments, by report	0-20		No	Not to be used for Nitrous Oxide or conscious sedation.	
D9910	application of desensitizing medicament	0-20		No		
D9920	behavior management, by report	0-20		No	Patient record must indicate the additional staffing required to complete the treatment. Patient record must indicate the type and/or types of behavior management techniques used.	
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		No		
D9940	occlusal guard, by report	0-20		No		
D9999	unspecified adjunctive procedure, by report	0-20		Yes	For hospital operating room cases. Includes all workups, same day surgery visit, and discharge summary, etc. Cannot be billed with D9420. Requires prior approval.	

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Exhibit B Benefits Covered for
VA Smiles for Children - Over 21

Coverage for adults, age 21 or older is limited to medically necessary oral surgery and associated diagnostic services. Oral surgery procedures not listed in Exhibit B may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program. Contact DentaQuest with any questions about coverage and reimbursement.

Diagnostic services include the oral examination, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 12 Month(s) Per Provider OR Location. Limited examinations (D0140) are not reimbursable on the same day as codes D0150 and D9310.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One comprehensive exam per patient per dentist or dental group. Not covered with D0140, D9310 on same day.	
D0220	intraoral - periapical first radiographic image	21 and older		No		
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No		
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No		
D0251	extra-oral posterior dental radiographic image	21 and older		No		

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Exhibit B Benefits Covered for
VA Smiles for Children - Over 21

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 60 Month(s) Per Provider OR Location.	

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Exhibit B Benefits Covered for
VA Smiles for Children - Over 21

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. Minimum of four (4) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should only be requested when the patient is being treated with medications (e.g. dilantin) or other mechanical irritants such as orthodontic brackets that result in an irreversible growth of gingiva.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. Minimum of four (4) affected teeth in the quadrant. Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth. It should only be requested when the patient is being treated with medications (e.g. dilantin) or other mechanical irritants such as orthodontic brackets that result in an irreversible growth of gingiva.	pre-op x-ray(s), perio charting

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Exhibit B Benefits Covered for
VA Smiles for Children - Over 21

Extractions for adults, requires prepayment review and treatment must be considered medically necessary and complicating patient's general health and be documented as such by the dentist or medical provider. Documented radiographic dental periapical infection for abscessed teeth, severe caries/fractured teeth involving the nerve/pulp, or severe periodontal infection which causes acute pain/loss of appetite/weight due to pain/infection, or exacerbates a medical condition/medical management control such as diabetes, heart valve condition, etc, will be considered and reviewed.

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit B may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	narr. of med. necessity, pre-op x-ray(s)
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	narr. of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit B Benefits Covered for VA Smiles for Children - Over 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Will not be paid to the dentists or group that previously removed the tooth. Removal of asymptomatic tooth not covered. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	21 and older		Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes	Copy of pathology report with claim for pre-payment review.	Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes	Copy of pathology report with claim for pre-payment review.	Pathology report
D7288	brush biopsy - transepithelial sample collection	21 and older		Yes	Copy of pathology report with claim for pre-payment review.	Pathology report

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. Either D7320 or D7321. No extractions performed in edentulous area. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7321) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. Either D7320 or D7321. No extractions performed in edentulous area. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes	Copy of pathology report and narrative of medical necessity with claim for pre-payment review	narr. of med. necessity, pathology rprt
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes	Copy of pathology report and narrative of medical necessity with claim for pre-payment review	narr. of med. necessity, pathology rprt
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity

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Exhibit B Benefits Covered for VA Smiles for Children - Over 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7472	removal of torus palatinus	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D7473	removal of torus mandibularis	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Either D7510 or D7511. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient. Either D7510 or D7511. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D7880	occlusal orthotic device, by report	21 and older		Yes	Covered only for temporomandibular pain, dysfunction, or associated musculature. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Use of IV sedation and general anesthesia will be reviewed on a periodic basis. The service is not routinely used for the apprehensive dental patient. Medical necessity must be demonstrated. Use of nitrous oxide and conscious sedation will also be reviewed on a periodic basis, and patient medical records must include documentation of medical necessity.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Qualified Dental network providers are the only providers who can submit claims for general anesthesia/deep sedation or intravenous conscious sedation services and be paid by DentaQuest. For the claim to be paid the service must be delivered by that same provider. A dental provider not qualified to deliver general anesthesia/deep sedation or intravenous conscious sedation procuring this service from a general anesthesiologist, can not submit a dental claim for that service.

Use procedure code D9999 for all services connected with same day surgery. This includes the initial hospital care, history examination, initiation of diagnostic and treatment programs, prepartion of hospital records, consults with anesthesia and/or pediatrician and others, day surgery visit, and hospital discharge day management including the discharge summary.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9223	deep sedation/general anesthesia – each 15 minute increment	21 and older		Yes	Twelve of (D9223) per 1 Day(s) Per patient. Maximum of 180 minutes (12 units). Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	21 and older		Yes	Twelve of (D9243) per 1 Day(s) Per patient. Maximum of 180 minutes (12 units). Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes	Must be documented as a medically necessity in the patient records. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity

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Exhibit B Benefits Covered for VA Smiles for Children - Over 21

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	One of (D9310) per 1 Day(s) Per Provider OR Location. Not to be billed on the same day or within 6 months of another exam code. Oral evaluations and any consulting services are inclusive in the code. Not to be billed with any other treatment codes, except may be billed with diagnostic codes. Must be a consult request from a health care provider, excludes placement from DentaQuest.	
D9420	hospital or ambulatory surgical center call	21 and older		Yes	Maximum of three (3) for the same stay. Cannot be billed with D9999 for hospital care on the same date of service. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Not to be used for Nitrous Oxide, conscious sedation. Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	For hospital operating room cases. Includes all workups, same day surgery visits, and discharge summary, etc. Cannot be billed with D9420. Requires prior approval.	

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		Yes	One of (D0120) per 6 Month(s) Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0140	limited oral evaluation-problem focused	21 and older		Yes	Two of (D0140) per 12 Month(s) Per Provider OR Location. Limited examinations D0140 are not reimbursable on the same day as codes D0120, D0150 and D9310. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0150	comprehensive oral evaluation - new or established patient	21 and older		Yes	One of (D0150) per 6 Month(s) Per Provider OR Location. One of (D0120, D0150) per 6 Month(s) Per Provider OR Location. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0220	intraoral - periapical first radiographic image	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0240	intraoral - occlusal radiographic image	21 and older		Yes	Two of (D0240) per 12 Month(s) Per patient. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0251	extra-oral posterior dental radiographic image	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0270	bitewing - single radiographic image	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0272	bitewings - two radiographic images	21 and older		Yes	One of (D0272) per 12 Month(s) Per Provider OR Location. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D0330	panoramic radiographic image	21 and older		Yes	One of (D0330) per 60 Month(s) Per Provider OR Location. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

The application of topical fluoride treatment is allowed once every 6 months when provided in conjunction with a prophylaxis. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and is not a seperate topical fluoride treatment.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		Yes	One of (D1110) per 6 Month(s) Per Provider OR Location. Included scaling and polishing procedures to remove coronal plaque, calculus, and stains. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D1208	topical application of fluoride - excluding varnish	21 and older		Yes	One of (D1208) per 6 Month(s) Per Provider OR Location. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least twelve months, unless there is recurrent decay or material failure. Payment will be made for only one single surface restoration per tooth surface. For example, two separate occlusal (O) restorations on the same tooth are to be billed as one occlusal restoration. However, for example it is permissible to bill for multiple, but separate restorations involving the same tooth surface, such as a mesial-facial (MF) and a distal-facial (DF) restoration on the same anterior tooth.

The acid etching procedure is considered part of the restoration and is not billed as a separate procedure.

Local anesthetic is included in the restorative service or surgical fee and is not separately reimbursed.

A sedative restoration is considered a temporary restoration only and not a base under a restoration.

Bases, copalite, or calcium hydroxide liners placed under a restoration are considered part of the restorations and are not billable as separate procedures.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic substrate	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit C Benefits Covered for
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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2794	crown - titanium	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32	Yes	Not allowed within 6 months of placement. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D2940	protective restoration	21 and older	Teeth 1 - 32	Yes	One of (D2940) per 12 Month(s) Per patient per tooth. Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy, or on the same date of service as a restoration. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	Yes	Limit one per tooth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Payment for conventional root canal treatment is limited to treatment of permanent teeth.
The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DentaQuest Consultants.

Palliative treatment (sedative restoration) is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (exluding final restoration)	21 and older	Teeth 1 - 32	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D3330	endodontic therapy, molar (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
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For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A min of 4 affected teeth in the quadrant. Gingivectomies for the removal of hyperplasic tissue to reduce pocket depth. Request only when non-surgical treatment has not been effective or when the patient is taking medications that cause such conditions. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. 1 to 3 affected teeth in the quadrant. For removal of hyperplastic tissue. Should be only requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications that result in such conditions. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. A minimum of four (4) affected teeth in the quadrant. Periodontal charting with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Check service limit. Periodontal charting with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, perio charting

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Exhibit C Benefits Covered for
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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	21 and older		Yes	One of (D4355) per 12 Month(s) Per patient. Only covered when there is substantial gingival inflammation (gingivitis) in all four quadrants. Cannot be billed on same day with D1110. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D4910	periodontal maintenance procedures	21 and older		Yes	Four of (D1110, D4910) per 12 Month(s) Per patient. Any combination of D1110 and D4910 up to four (4) per 12 months. Covered following active treatment only (D4210, D4211, D4341, D4342). Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5213) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5214) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	21 and older		Yes	Not covered within 6 months of placement. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D5411	adjust complete denture - mandibular	21 and older		Yes	Not covered within 6 months of placement. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D5421	adjust partial denture-maxillary	21 and older		Yes	Not covered within 6 months of placement. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D5422	adjust partial denture - mandibular	21 and older		Yes	Not covered within 6 months of placement. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
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For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
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Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit C may be covered under the member's medical benefits through the Medicaid, FAMIS, or FAMIS Plus fee-for-service or managed care organization (MCO) program.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - deciduous tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32, 51 - 53, 64 - 69, 80 - 82	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction. Pre-operative radiographs with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82	Yes	Will not be paid to the dentist or dental group that removed the tooth. Removal of asymptomatic tooth not covered. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7260	oroantral fistula closure	21 and older		Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7261	primary closure of a sinus perforation	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes	Copy of pathology report with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pathology rprt
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes	Copy of pathology report with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pathology rprt
D7288	brush biopsy - transepithelial sample collection	21 and older		Yes	Copy of pathology report with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7311) per 1 Lifetime Per patient per quadrant. One of (D7310, D7311) per 1 Day(s) Per patient per quadrant. Either D7310 or D7311. Minimum of three (3) extractions per quadrant. Not allowed with a surgical extraction in same quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed in edentulous area. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7321) per 1 Lifetime Per patient per quadrant. One of (D7320, D7321) per 1 Day(s) Per patient per quadrant. No extractions performed in edentulous area. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes	Copy of pathology report and narrative of medical necessity with claim for pre-payment review Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes	Copy of pathology report and narrative of medical necessity with claim for pre-payment review Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7472	removal of torus palatinus	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7473	removal of torus mandibularis	21 and older		Yes	Narrative of medical necessity with claim for pre-payment review. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Exhibit C Benefits Covered for
VA Smiles for Children - Over 21 Pregnant Women

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Either D7510 or D7511. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient. Either D7510 or D7511. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D7880	occlusal orthotic device, by report	21 and older		Yes	Covered only for temporomandibular pain, dysfunction, or associated musculature Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

Use of IV sedation and general anesthesia will be reviewed on a periodic basis. The service is not routinely used for the apprehensive dental patient. Medical necessity must be demonstrated. Use of nitrous oxide and conscious sedation will also be reviewed on a periodic basis, and patient medical records must include documentation of medical necessity.

For all services that require pre-payment review, Providers have the option of requesting prior authorization.

Qualified Dental network providers are the only providers who can submit claims for general anesthesia/deep sedation or intravenous conscious sedation services and be paid by DentaQuest. For the claim to be paid the service must be delivered by that same provider. A dental provider not qualified to deliver general anesthesia/deep sedation or intravenous conscious sedation procuring this service from a general anesthesiologist, can not submit a dental claim for that service.

Use procedure code D9999 for all services connected with same day surgery. This includes the initial hospital care, history examination, initiation of diagnostic and treatment programs, prepartion of hospital records, consults with anesthesia and/or pediatrician and others, day surgery visit, and hospital discharge day management including the discharge summary.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		Yes	Not allowed with any other services other than radiographs and emergency exam. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9223	deep sedation/general anesthesia – each 15 minute increment	21 and older		Yes	Twelve of (D9223) per 1 Day(s) Per patient. Maximum of 180 minutes (12 units). Narrative documenting medical necessity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	21 and older		Yes	Twelve of (D9243) per 1 Day(s) Per patient. Maximum of 180 minutes (12 units). Narrative documenting medical necessity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9248	non-intravenous moderate (conscious) sedation	21 and older		Yes	Must be documented as a medically necessity in the patient records. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		Yes	One of (D9310) per 1 Day(s) Per Provider OR Location. Not to be billed on the same day or within 6 months of another exam code. Oral evaluations and any consulting services are inclusive in the code. Not to be billed with any other treatment codes, except may be billed with diagnostic codes. Must be a consult request from a health care provider, excludes placement from DentaQuest. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9420	hospital or ambulatory surgical center call	21 and older		Yes	Maximum of three (3) for the same day. Cannot be billed with D9999 for hospital care on the same date of service. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	One of (D9610) per 1 Day(s) Per patient. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Not to be used for Nitrous Oxide or conscious sedation. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		Yes	Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	For hospital operating room cases. Includes all workups, same day surgery visit, and discharge summary, etc. Cannot be billed with D9420. Requires prior approval. Narrative documenting medical necesssity, including pregnancy status and due date, with claim for pre-payment review.	narrative of medical necessity

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