DentaQuest

LOUISIANA MEDICAID DENTAL PROGRAM OFFICE REFERENCE MANUAL

Managed by DentaQuest USA Insurance CO., LLC.
PO Box 2906
Milwaukee, WI 53201-2906
800-508-6785

The Office Reference Manual is subject to periodic updates; please ensure that you are using the latest version. The most current copy can be found online at https://dentaquest.com/getattachment/State-Plans/Regions/Louisiana/Dentist-Page/la-medicaid-office-reference-manual.pdf? Lang=en-US
Each quarter you can find what sections received updates or changes in your provider newsletter.

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Date	Section	Change
11/1/21	Entire Document	DentaQuest has updated the document to provider direct links to web portals and other direct locations for providers.
11/1/21	1.02	DentaQuest clarified that provider may appeal on behalf of member with consent.
11/1/21	Introduction	DentaQuest is adding the link for Louisiana Medicaid Fee schedule
11/1/21	3.04	Adding “Louisiana” to Only a Louisiana licensed health care provider makes the clinical denial of care determinations.
11/1/21	3.04	Adding Language: If approved the provider should receive a detailed approval of services from DentaQuest to continue with the procedures.
11/1/21	4.01	DentaQuest for prior authorization of dental treatment to be performed in the medical facility if a patient is over the age of 5. is age six and over.
11/1/21	5.00	Payer ID CX014 and to claims submission section
11/1/21	5.10	Adding clarifying language Based on the LDH DBPM Program Contract, participating Providers shall hold Members, DentaQuest, and/or the Department of Health harmless for the payment of non-covered Services except as provided in this paragraph.
11/1/21	7.0	Clarified Provider Complaint: A provider complaint is defined as any verbal or written expression, originating from a provider and delivered to any employee of the DBPM, expressing dissatisfaction with a policy, procedure, payment or any other communication or action by the DBPM, excluding a request for reconsideration or appeal of specific claims. It does include general complaints about claim payment policies.
11/1/21	7.01	(Please include all related documents and member consent form) added to clarify language
11/1/21	7.02	Rearranged the complaint process section for fluidity and allowed for the PE Reps to be the first point of provider contact.
11/1/21	7.03	Removed a duplicate section in the complaint appeal process.
11/1/21	15.01	Updating language to clarify value add language
11/1/21	15.04	Updating stainless steel crown language Appropriate diagnostic radiographs clearly showing the pathology or cariesdetecting intra-oral photographs if radiographs could not be made for the ages of 5-20 on teeth D, E, F, G, N, O, P and Q.
11/1/21	15.09	Providers rendering sedation services must have submit for the appropriate procedures being completed in that clinical session. If additional sedation time was used, the provider should submit the claim and sedation log post the clinical session for the level of sedation provided.
11/1/21	Exhibit B	Updated the Value Add Benefits including exam and x-rays.
4/25/22	Exhibit C	Updated the Rate Fee for CDT code D7210 to reflect the correct paid amount in exhibit C Value Added benefits for Adult Denture Program.
4/25/22	Exhibit E	Added newly implemented fee schedule and benefit limitation table for the Adult Waiver Program starting 7/1/2022.
6/16/2022	15.18	Louisiana is opening up Teledentistry to FQHC facilities **ONLY** starting 7/1/2022

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Address and Telephone Numbers

DentaQuest Customer Service
Member Services: 800.685.0143
Provider Services: 800.508.6785
PO Box 2906
Milwaukee, WI 53201-2906

Fax numbers:
Claims to be reprocessed:262.834.3589

Claims Questions:
denclaims@dentaquest.com

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

TDD/TTY (Hearing Impaired):
800.466.7566

Special Needs Member Services:
800.660.3397

LDH Fraud Hotline:
800.488.2917 for Provider Fraud
833.920.1773 for Recipient Fraud

Web Site:
www.dentaquest.com

State of Louisiana Louisiana Department of Health P. O. Box 629
Baton Rouge, LA 70821

Credentialing
PO Box 2906
Credentialing Hotline: 800.233.1468 Fax: 262.241.4077

Authorizations should be sent to:
DentaQuest – Louisiana Medicaid Dental Authorizations PO
Box 2906
Milwaukee, WI 53201-2906
Fax: 262.241.7150 or 888.313.2883

Outpatient/Hospital Fax:
262.834.3575 Dental claims should be sent to:
DentaQuest – Louisiana Medicaid Dental Claims
PO Box 2906 Milwaukee,
WI 53201-2906

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

Complaints Grievances & Appeals
DentaQuest – Louisiana Medicaid Complaints Grievances & Appeals PO Box 2906
Milwaukee, WI 53201-2906 Fax: 262.834.3452
Or Via Provider Web Portal

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DentaQuest's Commitment Culturally Competent Care

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

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

Principal Clas Standard

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

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

Theme One — Governance, Leadership, And Workforce

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

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

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

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

Theme Two — Communication And Language Assistance

CLAS Standard Five: Offer language assistance, at no cost, to individuals who have limited-English proficiency and/or other communication needs in order to facilitate timely access to health care and services.
Through continued efforts to build prominent and mutual partnerships with our providers, DentaQuest is dedicated to assisting members with access to timely dental service and quality care. This commitment is accomplished through ongoing quality process improvement consisting of data collection from member complaints and surveys and analysis of the data.

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While there are opportunities to improve access to health care, the established monitoring process has been instrumental in targeting areas for improvement.

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

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

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

Theme Three — Engagement, Continuous Improvement, And Accountability

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

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

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

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

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

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

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

DentaQuest has established civil rights and grievance protocols to ensure that complaints of discrimination related to the provision of and/or access to covered healthcare benefits are reported and investigated by DentaQuest in accordance with the requirements of all applicable federal and state civil rights laws. DentaQuest employs a Civil Rights Coordinator to effectuate DentaQuest's processes relating to discrimination complaints for enrollees and employees.

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

DentaQuest recognizes that members receive their advice and guidance from various entities in the community. DentaQuest will continuously seek opportunities to improve its member outreach

Language Assistance (LEP)

For dental practices that receive certain federal financial assistance from HHS, the Sec. 1557 final rule will require that they post notices of nondiscrimination as well as taglines in the top 15 non-English languages spoken in the state indicating that free language assistance services are available. The notices must be posted in the dental office, on the website and in any significant publications and communications. For smaller items, such as postcards and tri-fold brochures, the practice may use a shorter nondiscrimination statement and taglines in the state's top two non-English languages spoken.

Post and have a policy that states they will not discriminate against LEP including availability of language assistance services in at least the top 15 non-English languages spoken in Tennessee

Auxiliary aids and services are available under Title III of the ADA and Section 504 of the Rehabilitation Act of 1973. For more guidance see:

- www.ada.gov
- http://www.ada.gov/taman3.html
- http://www.hhs.gov/ocr/civilrights/resources/laws/index.html

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of Members. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found on line at

- http://www.lep.gov/ISpeakCards2004.pdf.

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- Sample notices and translations
- http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/indes.html

Introduction

Program Objective

The primary objective of the DentaQuest Louisiana Medicaid Dental program is to create a comprehensive dental care system offering quality dental Covered Services that are Medically Necessary to eligible Louisiana residents. We emphasize early intervention and promote access to necessary dental care, thereby improving health outcomes for Louisiana residents.

Are you building a "Dental Home" for your members?

Effective January 1, 2021, DentaQuest USA Insurance Company, Inc. (DentaQuest) will be implementing the Dental Home program in Louisiana for Medicaid Members.

The Main Dental Home is a place where a child's oral health care is delivered in a complete, accessible and family-centered manner by a licensed dentist. This concept has been successfully employed by primary care physicians in developing a "Medical Home" for their Members, and the "Dental Home" concept mirrors the "Medical Home" for primary dental and oral health care. If expanded or specialty dental services are required, the general dentist is not expected to deliver the services, but to coordinate the referral and to monitor the outcome.

Provider support is essential to effectively employ the Dental Home program for Medicaid Dental Program Members. With assistance and support from dental professionals, a system for improving the overall health of children in the Medicaid Program can be achieved.

Dental Home Initiative

Providers who are contracted with DentaQuest for the Louisiana Medicaid Dental Program will automatically be included in the Dental Home Initiative.

Assigning members to a Dental Home

DentaQuest's Dental Home auto-assignment function follows the below hierarchy when assigning members to a dental home:

- If the member has history with a provider office, the member is assigned to the provider office with which they have history in order to support the continuation of an existing provider/member relationship.
- If the member does not have history with a provider office, but they have a family member that is assigned to a provider office, the member is assigned to the same provider office that their family member is linked to. This ensures family members are kept together.
- If the member does not have history or a family member assigned to a dental home, the member is assigned to the closest higher-performing provider office that is accepting new members and has open capacity.

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Member choice:

- A member may change their Dental Home at any time by calling the Customer Care team.

Provider Optimization

The intent of Provider Optimization is to increase access to care, ensure quality and reduce costs. To support Provider Optimization, DentaQuest:

- Monitors provider performance on a regular basis and delivers the Provider Performance Report which measures provider performance in these areas: a) Silver Diamine Fluoride, b) Sealants, c) Fluoride Treatments and identifies those providers that consistently deliver higher-quality care at an appropriate price point and those providers that need to improve.
- Reserves the right to move members away from their currently assigned dental home to a dental home providing higher-quality, lower-cost care if their current dental home has a history of performing lower-quality, higher cost care.

Providers are strongly encouraged to attend a minimum of one patient-centered dental home webinar annually. The patient-centered dental home is an important part of our partnership with you to enhance member participation and improve quality of care. Webinars will include helpful hints and practical information on how to increase your recalls and use the resources such as panel rosters in your practice patient outreach

Outreach and Wellness Initiatives – for EPSDT members

Through collaborative efforts with dental providers DentaQuest will work to improve the overall oral health of the Members served through the Louisiana Medicaid Dental program, increase access to care, prevent and manage oral disease. Annually DentaQuest will launch a comprehensive outreach program for to reach Members encouraging them to visit their dental home, have regular preventive check-ups and take an active role in their oral health care. Our dental home program emphasizes the many benefits of establishing a dental home, developing a PCD relationship and regular preventive care (EPSDT) including sealants, SDF and fluoride treatments. Dental Homes will be established for Members through an assignment process as stated on page 5.

We connect with Members to stress that preventive care is one of the best ways to achieve good oral and overall health. We disseminate this message to Members and their parents or authorized representative by employing multiple communications channels. These include as part of the DentaQuest Louisiana Medicaid Dental Annual Access Proposal:

- Member handbook
- Provider directory
- Welcome packets
- Broken appointment program
- Healthy Beginnings
- Grassroots rural, community and screening outreach events statewide
- Oral Health Matters – an educational series on important oral health topics
- Through providers via prevention-based programs, provider web portal and provider newsletters.

As the initiatives are launched dental providers will receive additional information.

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Case Management

DentaQuest's Case Management department has Outreach Coordinators and Case Managers on staff dedicated to assist members with complex medical or behavioral care needs. We provide care coordination for members experiencing barriers to care, including those who suffer severe mental or physical disability, I/DD members, poorly managed chronic health conditions, or who otherwise require specially trained dental providers and accommodations. For referrals to our
Case Management Department, please send a secure e-mail to:
DL-CaseManagement@greatdentalplans.com

Member's or authorized representatives who call our Member Services Department (800-865-0143) may also ask to be directed to Case Management if the Member Services Representative is unable to assist them due to the presence of complex care needs such as described above.

Medically Necessary Covered Services

DentaQuest is responsible for administering Louisiana Medicaid Dental Program-covered dental benefits as medically necessary for Medicaid eligible Members. A comprehensive list of the Covered Services codes can be found in Exhibit A of this manual. DentaQuest must provide coverage in a manner which satisfies all regulatory rules and regulations established through Louisiana's Medicaid Managed Care Program by The State of Louisiana, Department of Health.

Adult Waiver Program

DentaQuest will now administer eligible Louisiana Medicaid Adults Members an extended benefit for those who qualify for the Adult Waiver Program. In order to qualify for these benefits, a beneficiary must be enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver and be 21 years of age and older. A comprehensive list of the Covered Services codes can be found in Exhibit E of this manual.

1.00 General Information

1.01 Member Rights and Responsibilities

A. Introduction

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

B. Member Rights

As a Member of the Louisiana Medicaid Dental Program, Member rights include but are not limited to the following:

- to be treated with respect and recognition of their dignity and need for privacy;

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

Additional Member rights are as follows:

Confidentiality

All dental information about Louisiana Medicaid Dental Program Members is confidential. Members have the right to be treated with respect and recognition of their dignity and need for privacy when receiving their dental care. Provider and DentaQuest will ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.

Provider and DentaQuest shall hold confidential all information obtained by its personnel about Members related to their examination, care and treatment and shall not divulge it without the Member's authorization, unless:

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

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

DentaQuest and the Provider shall ensure all materials and information directly or indirectly identifying any current or former Member which is provided to or obtained by or

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through DentaQuest's performance of its contract with LDH, whether verbal, written, taped, or otherwise, shall be maintained in accordance with the standards of confidentiality of LA. Admin. Code Title 46 § XXXIII, Title 42, Part 2, Code of Federal Regulations, the Privacy Act of 1974, 5 USC 552a, the Medicaid regulations, 42 Code of Federal Regulations 431.300 et seq., IRC Section 6103(p), and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to LDH, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees.

Informed Consent

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

Emergency Services

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

Dental Records

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

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

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

Members have the right to receive an accounting of disclosures in the ten (10) years prior to the date the Member requests the accounting.

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

Discrimination

Not being discriminated against by your health care Provider on the basis of your age, sex, race, color, religion, physical or mental handicap, national origin, economic status or

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payment source, type/degree of illness or condition, or any other classification protected by federal and state laws and regulations.

Providers shall agree to cooperate with LDH and DentaQuest during discrimination complaint investigations. In addition, the Provider must assist Louisiana Medicaid Dental Program enrollees in obtaining discrimination complaint forms and assistance from DentaQuest with submitting the forms to LDH. A copy of LA Medicaid Member Grievance Appeal Form can be found online via provider portal, under documents section; see Appendix A of this document for a full list of forms.

DentaQuest and the Provider shall comply with Title III of the Americans with Disabilities Act of 1990 in the provision of equal opportunities for enrollees with disabilities. In the event that a reasonable modification or effective communication assistance in alternative formats for an enrollee is not readily achievable by the Provider, DentaQuest shall provide the reasonable modification or effective communication assistance in alternative

formats for the enrollee unless DentaQuest can demonstrate that the reasonable modification would impose an undue burden on DentaQuest.

Auxiliary aids and services are available under Title III of the ADA and Section 504 of the Rehabilitation Act of 1973. For more guidance see:
www.ada.gov
http://www.ada.gov/taman3.html
http://www.hhs.gov/ocr/civilrights/resources/laws/index.html

Non-Discrimination Compliance Resources

Contact information for non-discrimination compliance offices are as follows:

Department of Health
Phone: 225.342.9500

You can also write to: Louisiana Department of Health
P. O. Box 629 | Baton Rouge, LA 70821-0629

Language Assistance Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. The Executive Order signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

Providers can call DentaQuest Provider Service at 800-508-6785 should an office need to request language assistance for a DentaQuest enrollee.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to

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Louisiana Medicaid and it is not permissible to charge a Louisiana Medicaid Member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at https://www.justice.gov/crt/fcs/TitleVI

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of Louisiana Medicaid Members. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found online at https://www.commerce.gov/bureaus-and-offices/census

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers cannot locate interpreters specializing in meeting needs of LEP clients by calling the translation numbers listed at the front of this guide.

Providers may also consider:

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

Advance Directives

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

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

Member Appeals

Members shall have the right to file appeals regarding adverse actions taken by DentaQuest or the Provider. The term "Appeal" shall mean a Member's right to contest verbally or in writing, any "Adverse Action" taken by DentaQuest or the Provider to deny, reduce, terminate, delay or suspend a covered service, as well as any other acts or omissions of DentaQuest or the Provider that impair the quality, timeliness, or availability of such benefits. An Appeal may be filed by the Member or by a person authorized by the Member to do so, including but not limited to, a Provider with the Member's consent. DentaQuest shall inform Members of their Appeal rights in the Member Handbook. See section 7.00 of this manual for specific Appeal guidelines. Information on Appealing a Medicaid Decision | Department of Health | State of Louisiana (la.gov)

Member Grievance

A Member "Grievance" shall mean a Member's right to contest an action taken by DentaQuest or the Provider that does NOT meet the definition of Adverse Action. For

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example, a Grievance may arise due to how the Member was treated by the Provider or the Provider's staff during an office visit (i.e. rude or inappropriate behavior or not answering the Member's questions) or if the Member feels that a DentaQuest staff Member treated him/her inappropriately (i.e. being rude during a phone call, or not returning a Member's phone calls). DentaQuest shall inform Members of their Grievance rights in the Member Handbook. LDH takes Member's Grievances very seriously and requires DentaQuest and DentaQuest's Providers to do the same. See section 7.03 of this manual for specific guidelines pertaining to handling Member Grievances.

Information
Members have the right to be provided with information about the services offered by Louisiana, the Louisiana Medicaid Dental Program, DentaQuest, or the dental practitioner providing the care and their own personal rights and responsibilities.

C. Member Responsibilities

Enrollment in the Louisiana Medicaid Dental Program carries certain Member responsibilities. While all Members receive a handbook that details those responsibilities, Providers are also encouraged to familiarize themselves with Member responsibilities.

Those responsibilities include:

- Knowing and understanding the terms, conditions, and provisions of the Louisiana Medicaid Dental Program and DentaQuest and abiding by them.
- Informing the Customer Service Department at DentaQuest, LDH, and his/her Department of Children and Family Services (DCFS) case worker regarding any change in residence and any circumstance which may affect entitlement to coverage or eligibility.
- Following preventive health guidelines, prescribed treatment plans and guidelines given by those providing health care services.
- Scheduling or rescheduling appointments and informing your Provider when it is necessary to cancel an appointment.
- Showing your Louisiana Medicaid/MCE ID card whenever you receive health care or prescription medication.
- All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health services.
- All Members have the responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
- All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

1.02 Provider Rights and Responsibilities

A. DentaQuest Participating Providers have a right to:

- Receive information about Louisiana Medicaid, its services, and its Members' rights and responsibilities.

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- Be informed of the status of their credentialing or re-credentialing application, upon request.
- Object to rules, policies, procedures, or decisions of DentaQuest or Louisiana LDH, as set forth in this document and your provider agreement.
- File an appeal as delineated in this Provider Office Reference Manual.
- Not be discriminated against with regard to participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- Not be discriminated against for specializing in conditions that require costly treatment.
- Recommend a course of treatment to a Member, even if the course of treatment is not a Covered Service or approved by the Louisiana Medicaid Dental Program. However, the Provider must inform the Member that DentaQuest will only pay for covered services that are medically necessary that the Member is eligible to receive under the Louisiana Medicaid Dental Program.
- Communicate with Members regarding dental/treatment options.

- Specify the functions and /or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional practice. However, DentaQuest will only pay for covered services that are medically necessary that the Member is eligible to receive under the Louisiana Medicaid Dental Program.

- Recommend input into DentaQuest's Louisiana Medicaid Rules, Policies and Procedures. These Rules, Policies and Procedures are available on the DentaQuest's website https://dentaquest.com/getattachment/State-Plans/Regions/Louisiana/Dentist-Page/la-medicaid-provider-training-webinar.pdf?lang=en-US
- To request a State Fair Hearing on behalf of a member. (Please see section 7.0 Appeals and Grievances)

B. DentaQuest Louisiana Medicaid Dental Program Participating Providers have the responsibility to:

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

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

Abide by the accessibility and availability standards as set forth:

- <u>Urgent care – defined as the need for immediate medical service for the treatment of acute or chronic illness or injury. Urgent care, including urgent specialty care, must be provided within 24 hours of request. A request that does</u>

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not require prior authorization must be provided within 24 hours of request and within 48 hours for a request for services that do require prior authorization.
- Primary Dental Care – within 30 days.
- Follow-Up Dental Care – within 30 days after assessment.

C. Annual Informational Sessions and Webinars
DentaQuest and the Department of Health of Louisiana strongly encourage all providers to attend as many offered sessions as possible and a minimum of one annually. Invitations to sessions and webinars will be posted on the portal and sent via email so you can attend.

1.03 Provider Data and Operations

A. Updating Your Information
It is important to ensure that you provide updates to DentaQuest at least 30 days in advance for any changes in information for your practice per your provider agreement. The Department of Health has requested we send out all communications by email so having a valid up to date email on file with DentaQuest is critical to ensure you receive

all communications in a timely manner. What you provide to DentaQuest should match what you attest to quarterly in CAQH. An update form can be found in the forms section of this manual and should be emailed to standardupdates@dentaquest.com

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

B. Existing Patients Only (EPO) Status Changes
For those providers who wish to no longer accept new patients, the following EPO requirements apply:
- Providers must give 30 day advance written notice and a completed update form is required to be submitted
- Provider will be listed as EPO for **30 days and then EPO status will be removed**

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), in addition to coverage under Louisiana's Medicaid Managed Care Program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), services of Members under age 21 shall be made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and provide treatment to correct or

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ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered. However, DentaQuest will only pay for covered services that are medically necessary that the Member is eligible to receive under the Louisiana Medicaid Dental program.
Pursuant to 42 USC §1396d(r), EPSDT services shall at a minimum include:

C. Screening services provided at intervals:

a) which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care
b) indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions

D. Dental Services which are provided:

a) at intervals which meet reasonable standards of dental practice as determined by the State after consultation with recognized dental organizations involved in child health care and
b) at such other intervals, indicated as Medically Necessary, to determine the existence of a suspected illness or condition and

c) which shall at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health. However, DentaQuest will only pay for covered services that are medically necessary that the Member is eligible to receive under the Louisiana Medicaid Dental program.
d) Diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services are covered, regardless of whether or not such services are covered under the State plan. However, DentaQuest will only pay for covered services that are medically necessary that the Member is eligible to receive under the Louisiana Medicaid Dental Program.

E. Transportation assistance

Member should contact the Transportation Services number provided by the Member's Managed Care Organization (MCO) to arrange transportation services.

F. Definitions

42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, screenings must include, but are not limited to dental screening services furnished by direct referral to a dentist for children beginning eruption of first tooth.

Again, these screening services must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatric Dentistry Guidelines. Pursuant to the Louisiana Medicaid Dental Benefits Manager Contract with DentaQuest

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"screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics Recommendations For Preventive PediatricHealth Care.'" Should screenings indicate a need, the following services must be provided, dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health are covered even if the services are not included in the Plan and it is determined that they are covered services that are medically necessary under the Louisiana Medicaid Dental Program.

2.00 Member Eligibility Verification

2.01 State Eligibility System

The State of Louisiana provides the most up to date online eligibility access. For instructions, please go to https://www.lamedicaid.com/account/login.aspx

DentaQuest Eligibility System

DentaQuest issues eligible Members ID cards. The Provider's responsibility is to check the databases available to confirm eligibility before providing services. DentaQuest will only pay for covered services that are medically necessary and that the Member is eligible to receive under the Louisiana Medicaid Dental Program. If the Provider fails to verify that the Member is eligible for the services rendered and it is later determined that the Member was not eligible,

DentaQuest will not pay the Provider for the services rendered, and the Provider may not collect or attempt to collect the cost of such services from the Member, except as provided in Section 2.02 below.

EPSDT dental benefits end for Louisiana Medicaid Dental Program's beneficiary's at 12:00 AM on their 21st birthday. Example: Member's 21st birthday is June 1 so their dental benefits end at 12 am June 1, and they are no longer eligible for services starting that day. Members may still be on Louisiana Medicaid (and show eligible on the portal) but they will no longer have EPSDT dental coverage as part of their eligible benefits.

Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed provideraccess.dentaquest.com

Eligibility information received from either system will be the same information you would receive by calling DentaQuest's Provider Service department at 800-508-6785; however, utilizing either of these systems will Provide information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.
DentaQuest's Internet website also allows verification of a Member's eligibility, as well as the ability to submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or the Member's full last name and first initial. To access the eligibility information via DentaQuest's website, simply go to our website at provideraccess.dentaquest.com.

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You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Provider Service Department at 800.508.6785. Once logged in, select "Patient" and then "Member Eligibility Search" and from there enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Provider Service Department at 800-508- 6785. 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 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 Provider Service at 800-508-6785.
2. After the greeting, stay on the line for English or press 1for Spanish.
3. When prompted, press, or say 2 for Eligibility.
4. When prompted, press, or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press, or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the Member's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the Member ID.
7. Does the Member's ID have only numbers in it? If so, press or say 2. When prompted, enter the Member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another Member, get benefit information, get limited claim history on this Member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member. Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 800-508-6785. They will be able to assist you in utilizing either system.

2.02 Member Liability

Providers may seek payment from Members only in the following situations:

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

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- service, the Provider shall obtain such acknowledgment in writing prior to rendering the service.

- If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the Member that the services are not covered, the Member may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.
- Dates of service indicate that the Member was not eligible. Providers may not seek payment from DentaQuest Members when:
- The Provider knew or should have known about the Member's Medicaid eligibility or pending eligibility prior to providing services.
- The claim(s) submitted to DentaQuest for payment was denied due to Provider billing error or a DentaQuest claims processing error.
- The Provider accepted DentaQuest assignment on a claim and it is determined that a primary plan paid an amount equal to or greater than the Louisiana Medicaid allowable amount.
- The Provider failed to comply with Louisiana Medicaid and DentaQuest policies and procedures or provided a service that lacks Medical Necessity or justification.
- The Provider failed to submit or resubmit claims for payment within the time periods required by DentaQuest.
- The Provider failed to ascertain the existence of Medicaid eligibility or pending eligibility prior to providing non-emergency services. Even if the Member presents another form of insurance, the Provider must determine whether the Member is covered under Louisiana Medicaid.
- The Provider failed to inform the Member prior to providing a service not covered by Louisiana Medicaid or DentaQuest that the service was not covered, and the Member may be responsible for the cost of the service. Services, which are non-covered by virtue of exceeding limitations, are exempt from this requirement.
- The Member failed to keep a scheduled appointment(s).
- The Provider failed to follow Utilization Management (UM) notification or prior authorization policies and procedures.

2.03 Coordination of Benefits

Louisiana Medicaid is the payer of last resort. Dental claims for payment by DentaQuest must be submitted to the primary dental insurance (when applicable) prior to submission to DentaQuest for payment.

Participating Providers are responsible for billing applicable primary insurance prior to submitting a claim for payment by DentaQuest and ensuring that Medicaid is the payer of last resort.

Always submit the primary payment on the claim submitted. Please confirm that this has been completed prior to submitting claims to DentaQuest to avoid delayed reimbursement.
In Accordance with Louisiana Medicaid program requirements, DentaQuest payment for a covered service is considered payment in full. Participating providers are required to accept DentaQuest's payment as payment in full.

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3.00 Utilization Management

Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on Medicare and State Medicaid guidelines, National Correct Coding Initiatives, professional educational materials, specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, as well as the information contained in the current CDT© and CPT© Manual published by the American Dental and American Medical Associations. Specialty organizations include:

- The American Academy of Pediatric Dentistry
- The Academy of General Dentistry
- The American Endodontic Society
- The American Orthodontic Society
- The American Association of Oral and Maxillofacial Surgery

Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must:

1. Provide for consistency.
2. Allow for individualized application.
3. Be consistent with generally accepted professional medical standards.
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
5. Ensure the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity.
6. Be formulated in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or the Provider, e.g. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity.
7. Not be established based in any way on the goal of limiting services, access, or financial incentive.
8. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
9. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.

3.00 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State

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Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there are no patient co-payments, these dollars represent all the reimbursement available to the dentist. This information can be found at https://www.lamedicaid.com/provweb1/fee_schedules/Dental_Fee.htm.

These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

DentaQuest does not require service authorization for emergency dental services. Dentists can request a Peer to Peer for clinical denials on the provider portal- provideraccess.dentaquest.com.

3.01 Community Practice Patterns

DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist’s treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the “community practice patterns” of local dentists and their peers. With this in mind, DentaQuest’ s Utilization Management Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers. All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest’s Utilization Management Programs recognize that there exists a normal variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

Where community practice patterns are inconsistent with Louisiana Medicaid’s medical necessity criteria and the dental necessity guidelines presented in this Office Reference Manual, Louisiana Medicaid Rules and dental necessity guidelines will take precedence. Procedures that have been identified as inconsistent with these policies should not be included in any statistical analysis or evaluation of provider performance. For example, if a community of dentists practice prophylactic stainless steel crown use, which is excluded from coverage under the Louisiana Medicaid Dental Program because it does not comport with Louisiana Medicaid’s rules for medical necessity, these procedures will be excluded from provider averages and comparisons.

3.02 Evaluation

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

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

Therefore, with the objective of ensuring the fair and appropriate distribution of these budgeted

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Medicaid Assistance Dental Program dollars to dentists, DentaQuest' s Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

3.03 Medical Necessity Guidelines

Medically Necessary is defined by statute in LAC 50: I.1101. These laws are implemented in LDH rules as well as the clinical criteria in this manual. The following are the basic medical necessity criteria. In order to be considered medically necessary, services must be

Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

- Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.
- Recommended by a licensed physician who is treating the Member or other licensed healthcare provider practicing within the scope of his or her license who is treating the Member • It must be safe and effective.
- It must not be experimental or investigational; and
- The convenience of a Member, the Member's family, the Member's caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.
- All medically necessary covered services, including continuation of services, are provided, whether the condition existed prior to any screening and regardless of whether the need for such services was identified by a provider whose services had received prior authorization from DentaQuest or by an in-network provider. DentaQuest does not employ or allow others to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individual determination of medical necessity based upon the needs of each DentaQuest Louisiana Medicaid Member and his/her history.

If a participating Provider fails to comply with the medical necessity guidelines for any procedure, DentaQuest will initiate corrective action, which may include imposition of prior authorization for this procedure.

3.04 Standard and Expedited Prior Authorization Procedure:

The authorization request, along with any additional documentation, is reviewed by the Clinical Review Specialist ("CRS") in the Utilization Management Department in accordance with the Plan design and Provider Office Reference Manual. Clinical Review Specialists do not finalize determinations. They conduct a preliminary review and prep the request for the LA licensed dentist.

Review Process: The Clinical Review Specialist approves the service as a covered benefit if the requested service and submitted documentation are consistent with the Plan benefit design and clinical algorithm.

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- If the requested service requires a denial based on medical necessity or the appropriateness of care, the request is routed to one of DentaQuest's licensed Clinical and/or Dental Consultants for review and determination.

- All clinical denials must be reviewed and signed off by a Clinical and/or Dental Consultant.

Time frames: unless specified differently by the Plan or regulation, determinations are completed within the following time frames from the receipt of the request:

- Standard: fourteen (14) calendar days maximum*;

*Note: The fourteen-day standard turnaround is the maximum time allowed by the LDH contract that DentaQuest has to process a standard authorization. In practice, DentaQuest processes most standard authorizations within 2 business days.

The decision-making timeframes must accommodate the urgency of the situation and must not result in the delay of the provision of covered services to Members beyond the required specified time frames.

If the request lacks clinical information, DentaQuest may extend the non-urgent pre-service timeframe for up to 14 calendar days. DentaQuest will provide written notice to the enrollee of the reason for the extension as well as the right to file a grievance. An extension may be taken under the following conditions:

- The Member or the Provider requests an extension; or
- There is a justified need for additional information and extension is in the Member's interest. In these cases, DentaQuest will notify the Member in writing of the intent to extend the timeframe.

DentaQuest may extend the expedited pre-service timeframe due to a lack of information, once, for up to 14 additional calendar days, under the following conditions:

- Within 24 hours of receipt of the expedited pre-service request, DentaQuest asks the provider, member or the member's representative for the specific information necessary to the make the decision.
- DentaQuest gives the provider, member or member's authorized Representative at least 48 hours to provide the information.
- The extension period, within which a decision must be made by DentaQuest begins a.) On the date when DentaQuest receives the response (even if not all of the information is provided), or

b.) At the end of the time period given to supply the information, if no response is received from the provider, member or the member's authorized representative.

In providing for emergent/urgent services and care as a covered service, DentaQuest does not:

- Require prior authorization for emergent/urgent service and care.
- Deny payment based on the member's failure to notify DentaQuest in advance or within a certain period of time after the care is given

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Emergent/Urgent services are covered in the following situations:

- To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably; would have believed that an emergency medical condition existed

Although DentaQuest does not require an authorization for emergency services, in the instance where a dental provider insists on the submission of a request for authorization, an authorization to render urgent, and not emergent services, as defined in this policy, are provided within seventy-two (72) hours of request. Upon receipt of the claim for payment, dental records are reviewed, and the claim paid in accordance with the guidelines for emergency services, as defined in this policy.

DentaQuest will not downgrade the status of Urgent authorization requests received from a treating provider and will be processed as requested.

- All Member plan benefit and eligibility data is stored in DentaQuest's system. Upon entering an authorization, the system requires the selection of an eligibility period prior to processing, allowing the verification of eligibility. All Member plan benefits are linked to each individual Member; assuring that only covered benefits are authorized. Any non-covered benefits are systematically denied. Provider eligibility data is stored in DentaQuest's system. Any ineligible Providers are systemically denied.
- Only a Louisiana licensed health care provider makes the clinical denial of care determinations.
- The facility where the emergency/urgent service is rendered determines the dental emergency condition that requires emergent/urgent care, for the purposes of rendering needed emergent care.
- After emergency care is rendered and upon the receipt and review of a claim and corresponding dental records and if an emergency dental condition is present, the facility will be compensated for any covered services completed at their facility.

3.05 Retrospective Review/Pre-payment Review or Post Service

All retrospective reviews are determined in compliance with Utilization Management standards established by NCQA and URAC. The strictest timeliness standard is applied for all review decisions.

1. Review Process: The retrospective review claim is reviewed by the Clinical Review Specialist to determine coverage and to certify that the services were medically necessary. Clinical Review Specialist do not finalize determinations. They conduct a preliminary review and prep the request for the LA licensed dentist.

a.) The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care.

b.) A licensed dentist reviews all services denied for medical necessity.

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2. Retrospective Reviews are determined, and written notification of the decision sent to the Provider within thirty (30) calendar days from the initiation of the UM process and in no instance later than 180 calendar days from the date of service

3. If the request lacks clinical information, DentaQuest may extend the post-service timeframe for up to 14 calendar days, under the following conditions:

a.) The Member or the Provider requests an extension; or

b.) There is a justified need for additional information and extension is in the Member's interest. In these cases, DentaQuest will notify the Member in writing of the intent to extend the timeframe.

~~5~~4. The extension period, within which a decision must be made by DentaQuest begins

a.) On the date when DentaQuest receives the member's response (even if not all the information is provided), or

b.) At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

DentaQuest may deny the request if the information is not received within the timeframe, and the member may appeal the denial.

~~6~~5. A preauthorized treatment, service or procedure may only be reversed on retrospective review when:

a.) The relevant information presented upon retrospective review is materially different from the information presented during the preauthorization review

b.) The relevant information presented upon retrospective review existed at the time of the preauthorization review but was withheld or not made available

c.) DentaQuest was not aware of the existence of such information at the time of the preauthorization review

d.) Had DentaQuest been aware of such information, the treatment, service, or procedure being requested would not have been authorized.

Determinations for retrospective review are made using the same standards, criteria or procedures as used during the preauthorization review process.

4.00 Inpatient and Outpatient Hospital Services

4.01 Prior Authorization

Any proposal to render covered services that are medically necessary in an inpatient or outpatient surgical setting must be submitted to DentaQuest for prior authorization of dental treatment to be performed in the medical facility if a patient is age six and over.

DentaQuest will review prior authorization treatment plans submitted to determine the medical necessity for dental treatment in a medical facility. The preauthorization of dental treatment will be processed by DentaQuest. If approved the provider should receive a detailed approval of services from DentaQuest to continue with the procedures.

Providers will coordinate facility usage with the Medical Managed Care Organization (MCO) as necessary. Please note that DentaQuest is not responsible for paying facility or related

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anesthesia charges associated with the provision of covered services that are medically necessary and performed in an inpatient, outpatient or free-standing ambulatory surgical center.

It is DentaQuest's policy that services that require medical necessity review are reviewed by licensed professionals within its Utilization Management Department. Providers may submit requests as a prior authorization or prepayment review where appropriate and as defined within the Office Reference Manual with the exception of orthodontics. As DentaQuest permits all providers to obtain prior authorization, non-emergency treatment started prior to the UM Review is at the financial risk of the provider's office and may not be charged to the member unless balance billing is allowed by regulation. Where urgent or emergent services are necessary, defined as those services necessary to treat pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury or what a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate care is required, DentaQuest encourages the provider to treat the member and submit a completed claim and any necessary documentation marked for "Prepayment Review". The company does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. DentaQuest encourages providers to perform services in an office-based setting and not an Emergency Room visit.

5.00 Claim Submission

All claims payments are subject to clinical criteria requirements outlined in this manual in section 15.

Within five (5) business days of receipt of a clean claim, DentaQuest will perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication. Claims payment occurs on a weekly basis on Wednesday evenings.

A Clean Claim has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

DentaQuest will process and pay or deny, as appropriate, at least ninety percent (90%) of all clean claims for each claim type, within fifteen (15) business days of receipt.
DentaQuest will process and pay or deny, as appropriate, one hundred percent (100%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.

DentaQuest may pend claims because of missing or incomplete information.
If a clean claim is received, but additional information is required for adjudication, then DentaQuest may pend the claim and request in writing (notification via e-mail, website/Provider Portal or an interim Explanation of Benefits) all necessary information such that the claim can be adjudicated within established timeframes.

DentaQuest will fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

DentaQuest will pay providers interest at twelve percent (12%) per annum, calculated daily, for the full period in which the clean claim remains unadjudicated beyond the thirty (30) calendar

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day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.
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 is the cementation date. The completion date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

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

- Electronic claims via DentaQuest's website provideraccess.dentaquest.com
- Electronic submission via clearinghouses. Payer ID CX014
- HIPAA Compliant 837D IB_5010 File.
- Paper ADA approved dental format

5.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.
To submit claims via the website, simply log on to provideraccess.dentaquest.com. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest shouldhave contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Provider Service Department at 800.508.6785.
Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry." The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports, and charts) to the claim.
If you have questions on submitting claims or accessing the website, please contact our Systems Operations at 800.417.7140 or via e-mail at:
EDITeam@greatdentalplans.com

5.02 Electronic Attachments

The following tools are available to provider offices to streamline the submission of attachments for claims. The use of these applications is not required in order to participate in the program or submit claims electronically. Although there is a small fee for usage of these applications, there is no charge for a provider to submit a claim DentaQuest.

A. FastAttachTM

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

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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. OrthoCADTM

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 system.

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

5.03 Electronic Claim Submission via Clearinghouse

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

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

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

5.04 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system.

Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

5.05 NPI Requirements for Submission of Electronic Claims

In accordance with the 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/#/ and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group,
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• your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non- compliant.

5.06 Paper Claim Submission

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

DentaQuest Louisiana Medicaid PO Box 2906
Milwaukee, WI 53201

5.07 Coordination of Benefits

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claims. 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 infull and no further payment will be made on the claim.

5.08 Filing Limits

Participating Provider shall have no more than 365 calendar days from the date of rendering a health care service to file an initial claim with DentaQuest except in situations regarding

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coordination of benefits or subrogation in which case the Provider is pursuing payment from a third party or if a Member is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that DentaQuest receives notification from LDH or its designee of the Member's eligibility.
In the event that a provider has a filed a claim within the required 365 day filing period, but the claim is denied as a result of administrative guidelines such as: missing documentation, Member eligibility status, missing claim details, the claim may still be considered for reimbursement. Upon receipt of the missing information or change in Member status DentaQuest will reconsider the claim denial if the initial filing timeline can be verified as occurring within the required 365 filing period and the additional information received is sufficient to meet payment guidelines. In this scenario, DentaQuest will honor the initial filing date and process the claim accordingly. Please note ** DentaQuest's system will not automatically override the filing limits, therefore, a provider must contact DentaQuest provider services to assist with the handling of the claim to ensure that it does not deny for untimely filing.

5.09 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department at 800-508- 6785 with any questions you may have regarding claim submission or your remittance. Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

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

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

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

Via Fax:
262.241.4077

Or

Via Mail:
DentaQuest – Louisiana Medicaid Program ATTN: PDA Department
PO Box 2906 Milwaukee, WI 53201-2906

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

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

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

1. Go to https://dentaquest.com/state-plans/regions/louisiana/
2. Log in using your password and ID
3. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search."
4. The remittance will display on the screen.

5.10 Payment for Non-Covered Services

Based on the LDH DBPM Program Contract, participating Providers shall hold Members, DentaQuest, and/or the Department of Health harmless for the payment of non-covered Services except as provided in this paragraph.

Providers may bill a Member for non-covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- the services to be provided
- DentaQuest and/or the Department of Health will not pay for or be liable for said services; and
- Member will be financially liable for such services. If you reach an agreement to bill a Member for a non-covered service, do not submit the claim to DentaQuest. Submission of such services will render the arrangement with the Member null and void.

6.0 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.
- Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT- 4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Service department at 800-508-6785 or via email at denelig.benefits@dentaquest.com.

7.00 Appeals and Grievances

Members, or an authorized representative acting on the member's behalf, have the right to file grievances and appeals verbally or in writing at any time. A provider acting on behalf of a member, or a member's authorized representative, may submit grievances and appeals on behalf of members with the member's written consent. DentaQuest will provide acknowledgement in writing for each appeal or grievance.

Definition of Grievance

An expression of a member dissatisfaction about any matter other than an adverse benefit determination. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Member Grievance Process

Members, or an authorized representative acting on the member's behalf, have the right to file grievances verbally, in person, or in writing at any time. A provider acting on behalf of a member, or a member's authorized representative, may submit grievances and appeals on behalf of members with the member's written consent. DentaQuest will provide acknowledgement in writing within five (5) business days of receipt of each grievance. DentaQuest will review the grievance and provide written notice to the member of the disposition of a grievance no later than ninety (90) calendar days from the date DentaQuest receives the grievance. Information on Appealing a Medicaid Decision | Department of Health | State of Louisiana (la.gov)

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With written member consent per State of Louisiana Appeal information at link above, in order to file a grievance on a member's behalf you can:

- Contact DentaQuest Member Services at 800.685.0143
- Submit the request via mail to DentaQuest's Complaints, Grievance and Appeals Department.

DentaQuest – Louisiana Medicaid Dental Complaints, Grievance and Appeals PO Box 2906 Milwaukee, WI 53201-2906 At no time will a member be discriminated against because he or she has filed a grievance. We always respect our members' privacy. Anything said or written is kept confidential.

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

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

- Notice of Deficiency: If DentaQuest determines that the Provider is not in compliance with a requirement of the Provider Agreement (including, but not limited to, issues relating to a Member's Grievance) DentaQuest will issue a notice of deficiency identifying the deficiency and request a CAP detailing how the Provider intends to correct the deficiency. The Notice of Deficiency will also contain the deadline for the proposed CAP to be forwarded to DentaQuest and may also contain recommendations or requirements the Provider must include or address in the CAP.
- Proposed CAP: Upon receipt of a Notice of Deficiency, the Provider shall prepare a proposed CAP and submit it to DentaQuest for approval within the time frame specified by DentaQuest. The proposed CAP shall comply with all recommendations and requirements of the Notice of Deficiency and contain a proposed time by which the noncompliance will be corrected.
- Approved CAP Implementation: DentaQuest will review the proposed CAP and work with the Provider to revise it as needed. Once approved, the Provider shall be responsible for ensuring that all actions and documentation required by the CAP are completed in compliance with the CAP, to DentaQuest's satisfaction.
- Notice of Completed CAP: Upon satisfactory completion of the implemented CAP, DentaQuest shall provide written notice to the Provider. Until written approval is received by the Provider, the approved CAP will be deemed to not have been satisfactorily completed.
- DentaQuest shall track and trend all Member Grievances, timeframes and resolutions and ensure remediation of individual and/or systemic issues.
- DentaQuest submits contractually required reports regarding Member Grievances to LDH.
- Member Grievances pertaining to discrimination shall be handled in accordance with the separate Nondiscrimination process outlined in this manual in Section 1.01.

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Definition of Member Appeal
An Appeal is a request for a review of an action or decision by DentaQuest related to covered services or services provided. A member has the right to file an appeal. An action is defined as the denial or limited authorization of a requested service, including:

- The type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within specified timeframes
- Denial of a request to obtain services outside the network for specific reasons

Member Appeal Process
DentaQuest notifies the member and requesting provider of a decision regarding a request for a covered service through a Notice of Action Letter. If the member, member's representative, or provider disagrees with our decision, he or she can file an appeal.
Appeals filed by a provider on behalf of a member or a member's representative require the member's written consent.

An appeal may be filed 60 calendar days from date of ABD. written confirmation of verbal appeal request is no longer required. These revisions were made to conform with the managed care final rule 42 CFR 438.402(c)(3)(ii) and 438.406(b)(3).

DentaQuest will acknowledge receipt of a member appeal in writing.

Standard appeals will be resolved within 30 calendar days from receipt.,
DentaQuest or the member can request a 14 calendar-day extension if there is a need for

additional information and the delay is in the member's best interest. If an extension is needed by DentaQuest, we will notify the member in writing of the reason.

The member's benefits will not end while we review the appeal unless the member is taken out of the EPSDT or the Adult Denture program. A member will continue to receive current authorized services until one of the following occurs:

- The member withdraws the appeal.
- Ten (10) calendar days pass after DentaQuest mails the Notice of Action providing the resolution of the appeal unless the member requests a State Fair hearing with continuation of benefits until a State Fair Hearing decision is reached.
- A State Fair Hearing Officer issues a hearing decision against the member; or •
  The time period or service limits of a previously authorized service has been met.

Services may be continued until the appeal decision is made. The written appeal must clearly state that the member wishes to continue getting the services. The member may have to pay for the continued services if the final decision is that DentaQuest does not have to cover the services.

To file an appeal on behalf of a member (Please include all related documents and member consent form):

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- Contact DentaQuest Member Services at 800.685.0143
- Submit the request via mail to DentaQuest's Complaints, Grievance and Appeals Department.

DentaQuest – Louisiana Medicaid Dental Complaints, Grievance and Appeals
PO Box 2906
Milwaukee, WI 53201-2906

Member or authorized representative who has completed the DBPM's appeal process, may request a state fair hearing within 120 calendar days after receiving a notice of appeal resolution indicating that the DBPM is upholding in whole or in part the adverse benefit determination or if DBPM fails to adhere to the notice and timing requirements for appeal processing.

Expedited Appeals
If the member's appeal is about care that is medically necessary and needed soon, a dental professional who did not render the original denial decision and who has the relevant clinical experience will review the appeal on an expedited basis. An expedited review request may be filed verbally. It can also be filed in writing; however, it must include the member's written consent.

An expedited review process is available for a member appeal that is for pre-service medical necessity. This expedited review process may take place when DentaQuest determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. DentaQuest will make a decision about an expedited review request no later than 72 hours after we receive it. If DentaQuest denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and it will be resolved in 30 calendar days.

DentaQuest will contact the member by telephone to inform them of the decision to deny the expedited request. We will send a written notice indicating our denial of the request within two (2) calendar days. If the request for an expedited appeal is approved DentaQuest will send a written notice indicating our appeal determination within 72 hours.

Informal Reconsiderations
An informal reconsideration is the review of DentaQuest's decision about a service authorization request made at the request of a member or the member's authorized representative. If a member is dissatisfied with DentaQuest's adverse determination of a service authorization request they have the right to ask for an informal reconsideration. A service authorization request is any one of the following:

- Pre-Authorization
- Referral
- Second Opinion

This process will take no more than one (1) business day from the date we receive your request.

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You, with the member's consent, may ask for an informal reconsideration. An informal reconsideration may be requested verbally or in writing within 30 calendar days of when the member receives the Notice of Action from DentaQuest

DentaQuest will set up a meeting between the member, you and/or their representative and the clinical reviewer who made the adverse determination within one (1) business day of receipt of the request. If the clinical reviewer who made the determination will not be available within the specified timeframe, the Dental Director will select another clinical reviewer to meet with you.

DentaQuest will provide its response to the informal reconsideration request at the conclusion of the meeting. This meeting can be an in-person meeting.

Request for a State Fair Hearing
If a member is not happy with DentaQuest's decision about an appeal, they have the right to ask for a State Fair Hearing within 120 days of the date of DentaQuest's Notice of Appeal Resolution. The member must first exhaust DentaQuest's appeal process before requesting a State Fair Hearing. A provider may also request a State Fair Hearing on behalf of the member.

To request a State Fair Hearing on behalf of a member, you must first have the member complete and sign a one- page "LA Medicaid Authorized Rep" form, which you can download from our provider portal (www.dentaquest.com) provideraccess.dentaquest.com

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf.

To request a State Fair Hearing, call or write to:
- **DentaQuest Member Services: 800.660.6207**
- **DentaQuest – Complaints, Grievances and Appeals PO Box 2906 Milwaukee, WI 53201-2906**

Otherwise, you can also request a hearing by sending a letter to:
The Division of Administration – Administrative Law Judge Division
654 Main Street
PO Box 44033
Baton Rouge, Louisiana 70804-4033

A member's benefits will not end during the State Fair Hearing unless they are taken out of the EPSDT Dental or the Adult Denture program. If the member wants to continue to receive the services that were denied, the member must inform DentaQuest within 10 days from the date on the Notice of Action and before the intended effective date of DentaQuest's action. The member may have to pay for the services if the final decision is that DentaQuest does not have to cover them.

Once a decision is made, all administrative remedies with the Louisiana Department of Health have been exhausted. If the member is dissatisfied with this ruling, he/she has the right to seek

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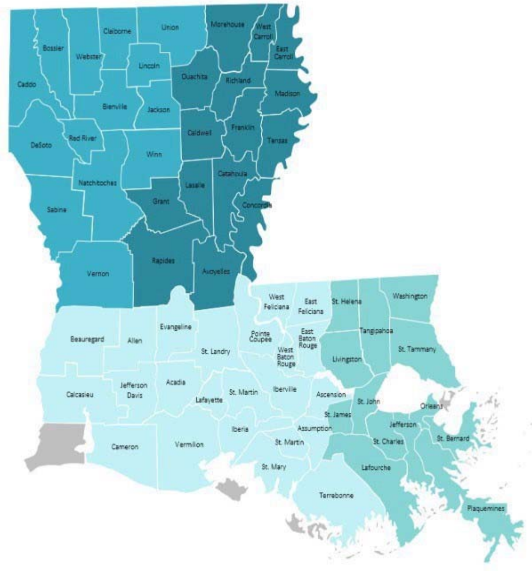
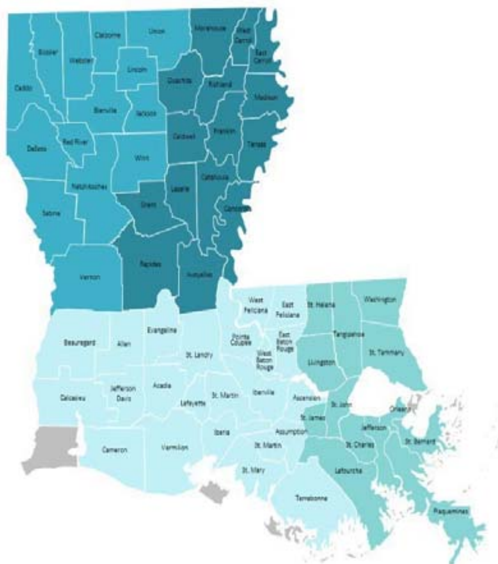
judicial review in accordance with Louisiana Revised Statute 46:107(C). The request for judicial review may be filed either in the 19th Judicial District Court, Parish of East Baton Rouge, or the district court of the parish of their domicile, within 30 days from the date of this certification.

Provider Assistance Complaint Process
DentaQuest makes every effort to provide the highest quality of service to our members and providers. We understand there are times when issues need to be discussed, and our Provider Services team is ready to help.



You can email your local Provider Engagement Representative LouisianaProviders@DentaQuest.com or contact the Provider Services: 800.508.6785 for assistance with any issue or complaint.



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~~You can email your local Provider Engagement Representative at LouisianaProviders@DentaQuest.com or the provider partner in your geographic region. or contact the Provider Services: 800.508.6785 for assistance with any issue or complaint.~~

A provider complaint is defined as any verbal or written expression, originating from a provider and delivered to any employee of the DBPM, expressing dissatisfaction with a policy, procedure, payment or any other communication or action by the DBPM, excluding a request for reconsideration or appeal of specific claims. It does include general complaints about claim payment policies.

Provider complaints may be reported verbally by calling Provider Services: 800.508.6785 or the designated provider partner in your geographic area. If the issue cannot be resolved by the Provider Services Representative or provider partner, the call will be escalated to the Complaints, Grievances and Appeals department. Providers may also submit complaints via mail to the address below:

DentaQuest – Complaints, Grievances and Appeals PO Box 2906
Milwaukee, WI 53201-2906

Upon receipt of a complaint, the Complaints department will review the issue and forward it to or solicit the assistance of the appropriate DentaQuest operational department(s). We will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties while applying DentaQuest's written policies and procedures and resolve the complaint within 30 calendar days from the date we receive it. Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or claims included in the bundled complaint. When submitting a consolidated complaint, please include all applicable patients and/or claims and denote that the complaint is a consolidated complaint in the submission.

Upon resolution of the complaint, the Complaint department will inform the provider in writing of the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 days, the Complaint department will inform the provider in writing of the need for an extension. Concerns related to medical necessity are not addressed through the complaint system. They can be submitted through the appeal process.

You can utilize DentaQuest's peer-to-peer process for clinical denials to speak with one of our licensed dentists. Providers may call Provider Service at 800-508-6785 to request a Peer to Peer review for clinical denials.

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After a provider has exhausted DentaQuest's internal complaint process, if the provider is dissatisfied with the resolution they have the right to file a complaint directly with Louisiana Department of Health, including any issues or decisions that are not a unique function of DentaQuest. To file a complaint with LDH after you have completed DentaQuest's complaint process, please email healthy@la.gov or call (225) 342-9500.

Provider Appeals
Appeal requests must be filed within 60 days of the initial claim determination. Appeals may be filed when a claim has been denied for determinations related to medical necessity and benefit coverage. Any requested or supporting information such as x-rays or rationale should be included with the appeal submission. Providers may submit an appeal online through DentaQuest's Provider Portal. provideraccess.dentaquest.com.

Provider Claim Reconsiderations
Reconsideration requests must be filed within 365 days from the date of service. Requests for DentaQuest's reconsideration of a claim may be filed when a claim has been denied for anything other than medical necessity or benefit coverage including, but not limited to, the following examples:

- Timely filing
- Duplicate
- Member and Provider eligibility
- Incorrect fee applied

Any supporting documentation should be included with the reconsideration request. Providers may submit their request on the Provider Portal provideraccess.dentaquest.com.

Providers may also mail an appeal to DentaQuest's Complaints, Grievances and Appeals department:
DentaQuest – Complaints, Grievances and Appeals PO Box 2906
Milwaukee, WI 53201-2906

Dental Benefit Plan Independent Review
This process was established by revisions La-RS 46:460.89, et seq. to resolve claims disputes when a provider believes a DentaQuest has partially or totally denied claims incorrectly. DentaQuest's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the DentaQuest's receipt of the claim is considered a claims denial.
There is a $250 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, then DentaQuest is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of DentaQuest, the provider is responsible for paying the fee.

The Louisiana Department of Health (LDH) administers the independent review process but does not perform the review of the disputed claims. When a request for independent review is

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received, LDH determines that the disputed claims are eligible for independent review based on the statutory requirements. If the claims are eligible, LDH will forward the claims to a reviewer that is not a state employee and is independent of both DentaQuest and the provider. The decision of the independent reviewer is binding unless either party to the dispute appeals the decision to any court having jurisdiction to review the independent reviewer's decision.
The independent review process is only one option a provider has to resolve claims payment disputes with a DentaQuest. In lieu of requesting independent review, a provider may pursue any available legal or contractual remedy to resolve the dispute.
To learn more about the independent review process, click here for the Information Packet for Independent Review. https://ldh.la.gov/index.cfm/page/3284.
To request independent review of disputed claims, click here for the Form to Request Dental Benefit Plan Independent Review.

Upon resolution of the complaint, the Complaint department will inform the provider in writing of the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 days, the Complaint department will inform the provider in writing of the need for an extension. Concerns related to medical necessity are not addressed through the complaint system. They can be submitted through the appeal process.

You can utilize DentaQuest's peer-to-peer process for clinical denials to speak with one of our licensed dentists. Providers may call Provider Service at 800-508-6785 to request a Peer to Peer review for clinical denials.

8.0 Fraud and Abuse

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

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

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

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

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

Louisiana Medicaid Fraud Hotline:
Call toll-free 1.800.488.2917 to report Provider Fraud complaints to LDH. Call toll-free 225.219.2575 to report Recipient Fraud complaints to LDH. Call toll free 800.433.3982 to report

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Fraud complaints to DentaQuest. You can find more information about reporting fraud and abuse at https://ldh.la.gov/index.cfm/page/219
Reporting directly to DentaQuest:
DentaQuest- Louisiana Medicaid Dental Plan Attention:
Utilization Review Department
PO Box 2906
Milwaukee, WI 53201-2906
Toll free at 800-508-6785

Policies and Procedures
DentaQuest, its subcontractors and providers shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La. R.S. 46:437.1- 437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.
False Claims Act Information Purpose
To provide information about the False Claims Act (the "FCA") and related legal requirements as required by the Deficit Reduction Act of 2005.

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

1. Federal False Claims Laws
The FCA, 31 U.S.C. §§ 3729-2733, imposes liability on any person or entity who knowingly files an unjustified or false claim for payment to Medicare, Medicaid, or other federally funded health program.
"Knowingly" means that a person has actual knowledge that the information on the claim is false; acted in deliberate ignorance of whether the claim is true or false; or acted in reckless disregard of whether the claim is true or false.
A person or entity found liable under the FCA is, generally, subject to three times the dollar amount that the government is defrauded and penalties of
$5,500 to $11, 000 for each false claim. If there is a recovery in the case brought under the FCA, the person bringing the suit may receive a percentage of the recovery. For the party found responsible for the false claim, the government may seek to exclude it from future participation in Federal healthcare programs or impose additional obligations against it.

2. Anti-Retaliation Protection
DentaQuest encourages personnel to report any concerns relating to potential fraud and abuse, including false claims.
The FCA states that no person will be subject to retaliatory action as a result of their reporting of credible misconduct.
Pursuant to DentaQuest's compliance with the FCA and other applicable DentaQuest policies and procedures, no team Member will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by DentaQuest solely because of actions taken to report potential fraud and abuse

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or other lawful acts by the team Member in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

3. Anti-Fraud Hotline

The DentaQuest Anti-Fraud hotline can be accessed by calling 800.433.3982 or the Louisiana Fraud and abuse hotline at 1.800.488.2917 for Provider Fraud complaints or 225.219.2575 for the Louisiana Recipient hotline for Fraud complaints.

We investigate all incoming calls to determine if the allegations are warranted. Based upon the information received from callers, the proper course of action is determined.

4. Monthly Screening requirement

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

“Exclusion Lists” means the U.S. Department of Health and Human Services’ Office of Inspector General’s List of Excluded Individuals/Entities (located at http://www.oig.hhs.gov) and the General Services Administration’s List of Parties Excluded from Federal Programs (located at https://www.verifycomply.com/ . LDH also provides an adverse actions website that can be used to check for individuals in eligible to participate in LA. Medicaid: https://adverseactions.ldh.la.gov/SelSearch

“Ineligible Persons” means any individual or entity who: (a) is, as of the date such

Exclusion Lists are accessed by the Provider, excluded, debarred, suspended or otherwise ineligible to participate in Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42U.S.C. § 1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

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

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

If Provider determines that an employee or contractor is or has become an Ineligible Person, Provider will take the appropriate action to remove such employee or contractor from responsibility for, or involvement with Provider’s operations related to Federal health care programs. In such event, the Provider shall take all appropriate actions to ensure that the

responsibilities of such employee or contractor have not and will not adversely affect the quality of care rendered to any DentaQuest Member of any Federal health care program.

5. Credible Allegation of Fraud

Pursuant to Federal law at 42 CFR 455.23 the Louisiana Department of Health may direct DentaQuest to suspend payments to a Provider where the Louisiana Department of Health has made a determination that there is a credible allegation of fraud against the provider that is currently under investigation. In the event of such a suspension the Provider must work directly

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with the Louisiana Department of Health to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Louisiana Department of Health.

6. Other Program Integrity Actions

DentaQuest is required in its contract to report all tips, confirmed or suspected fraud, waste and abuse to LDH Program Integrity and MFCU within 5 days of becoming aware of the issue. In addition, LDH conducts its own independent Program Integrity functions. In the event that a provider is contacted by the Louisiana Department of Health concerning a Program Integrity matter, the Provider must work directly with the Louisiana Department of Health to resolve this issue. Provider may contact DentaQuest if help is needed in obtaining a proper contact at the Louisiana Department of Health.

9.00 Quality Improvement Program (QIP)

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

Participating Providers shall cooperate with and participate in the quality improvement activities of DentaQuest to improve the quality of care and services and the members' experience, including in the collection and evaluation of data and participation in DentaQuest's quality improvement activities. This includes the use of practitioner performance data for quality improvement activities.

Participating Providers agrees to comply with any and all policies, rules and regulations of DentaQuest as they may exist from time to time including, but not limited to, claims processing, credentialing, quality or cost containment standards established by DentaQuest.
Cooperate by providing access to each Member's dental records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member complaints or grievances or as otherwise is necessary or appropriate subject to HIPAA and any and all pertinent laws.

Provide information and data, including, but not limited to, encounter, utilization, referral and other data, that DentaQuest may request.

That any and all Member records will be maintained for a period not less than the minimum required by State or ten (10) years, whichever is longer, and shall allow access to said records for review or audit upon request.

Allow duly authorized agents or representatives of DentaQuest, during normal business hours and other reasonable times, access upon demand to Participating Providers premises to inspect, audit, monitor or otherwise evaluate the performance of Participating Providers under this Agreement, including auditing claims submissions, evaluating and determining on a concurrent or retrospective basis the necessity or appropriateness of services provided to Members, evaluating through inspection or other means, the quality, appropriateness and

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timeliness of services provided under this Agreement, and pursuant to quality management programs or peer review programs.

Participating Providers shall produce all records, including copies of medical records, requested as part of such review or audit without charge. In the event right of access is requested under this paragraph, Participating Providers shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate personnel conducting the audit or inspections effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance Participating Providers activities.

The written Quality Management Program (QMP) Description clearly defines quality improvement structures, processes, and related activities to facilitate identification of opportunities for improvement on an ongoing basis.

In conjunction with the QMP Program Description, DentaQuest develops and maintains an Annual Work Plan that identifies QMP activities, yearly objectives, time frames for completion, and persons responsible for oversight of QMP activities and objectives.
The QMP Work Plan is considered a dynamic document that is updated on an on-going basis, as indicated. DentaQuest also conducts Performance Improvement Projects in accordance with LDH requirements.
DentaQuest uses the results of QMP activities to improve the quality of dental health in association with appropriate input from providers and Members. The evaluation of the QMP addresses Quality Monitoring studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP. This quality survey will be released annually to the provider network. Each provider will get specific notification.
The Quality Improvement Program includes:

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

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

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

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- Assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge. DentaQuest captures and stores special needs indicators in member records, provider records and claims in the operational systems. Providers servicing special needs populations are factored into the utilization review processes.

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

Whether a procedure requires prior authorization or not, all procedures require acceptable documentation standards be met. Documentation for all procedures rendered must justify the need for the procedure performed due to medical necessity.

Failure to provide the required documentation, 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. Additionally, the provider may be referred to the LDH Program Integrity section for possible actions impacting the provider's ability to participate in the Louisiana Medicaid Dental Program and other state Medicaid programs.

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

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

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

Provider Peer Review Committee

DentaQuest maintains a Provider Peer Review Committee composed of dentists currently licensed in Louisiana and in good standing with the Louisiana Board of Dentistry. This Committee meets regularly to review the processes, outcomes and appropriateness of dental care provided to enrollees by participating providers.

A copy of DentaQuest's QI Program is available upon request by contacting DentaQuest's Provider Service Department at 800-508-6785 or via e-mail at denelig.benefits@dentaquest.com.

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10.00 The Patient Record

DentaQuest

Participating Providers are required to maintain proper patient records.

10.1 Recordkeeping

Dental Record Standards – DentaQuest sets standards for dental records. These standards shall, at a minimum, include requirements for:

a. Member Identification Information - Each page in the record contains the patient's name or enrollee ID number.

b. Personal/biographical Data - Personal/biographical data includes age; gender; address; employer; home and work telephone numbers; and marital status; primary language spoken and translation needs.

c. Entries - All entries are dated on the day of service. Entries shall detail services provided and be signed by the rendering provider

d. Provider Identification - All entries are identified as to author.

e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.

f. List of current medications.

g. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (No Known Allergies - NKA) is noted in an easily recognizable location.

h. Past Medical History - (for Members seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For orthodontics requested secondary to speech pathology, obtain speech/language

i. Records, or orthodontics requested for a nutritional problem, pediatric records of diagnosis, growth records, and treatment for nutritional deficiency. For children, past medical history relates to prenatal care and birth.

j. Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up to date.

k. Diagnostic information. When submitting claims for services other than preventive or diagnostic services patient record must contain one or more of the following: radiographs, intraoral photos, charting of pathology, narrative in chart notes that includes reasoning for service. This is necessary to determine medical necessity.

l. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

m. Documentation of medical necessity of all procedures, including but not limited to sedation/anesthesia procedures and signed copies of consent forms

n. Tobacco Use - (For Members 12 years and over and seen three or more times) Notation concerning tobacco use is present. Abbreviations and symbols may be appropriate. **o.** Referrals and Results Thereof

p. Signed and dated consent forms as applicable

q. Emergency Care.

Impairment

r. Compliance with Louisiana Board of Dentistry Rule 28:1776. Suffering due to Substance– Records shall be kept separate and apart from the medical record in compliance with federal law.

s. Documentation of Advanced Directives as applicable

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Patient Visit Data – Documentation of individual encounters must provide adequate evidence of, at a minimum:
History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints, Date and begin and end times of service, Chief complaint or purpose of the visit, Diagnoses or dental impression, Objective findings, Studies ordered and results of those studies, Medications prescribed Name and credentials of the provider rendering services and the Initials of providers must be identified with correlating signatures, signed and dated consent forms, documentation of advanced directives appropriate.

a. Plan of Treatment.
b. Diagnostic Tests.
c. Therapies and other Prescribed Regimens.
d. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN.
Unresolved problems from previous visits are addressed in subsequent visits.
e. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Consultations for speech/language pathology include supporting documentation that the condition must be non-responsive to speech therapy without orthodontic treatment.
f. All Other Aspects of Patient Care, Including Ancillary Services.
g. Documentation of sedation (please see section 15.09).

10.02 Dental Record Alteration

Corrections/Alteration Protocols:

There are times when it is necessary to make a correction to a patient record; this need to make corrections should be an exception not a pattern. Any corrections, late entries, entries made out of sequence and addenda made in a patient record should be clearly marked as such in the record. A single line should be drawn through any erroneous chart entry and the word "error" should be noted; the correct treatment should be noted with the correct treatment referenced and these corrections should be signed and dated. In incidents where correction or alterations would need to be completed on a later date, the addenda and/or corrected treatment information should be entered "chronologically and refer to the date of visit in question. According to the American Dental Association Council on Dental Practice Division of Legal Affair publication" Dental Records" published in 2010:

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

According to CMS Program Integrity:
Any record that contains delayed entries, amendments, corrections, or addenda must be:

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- Clearly and permanently identify any amendment, correction, or delayed entry as such; and
- Clearly indicate the date and author of any amendment, correction, or delayed entry, and;
- Not delete but instead clearly identify all original content.”
- Corrections, amendments or delayed “entries to paper records must be clearly signed and dated upon entry in the record.”
- American Dental Association Dental Records – 2010
- CMS Manual System Pub 100-08

10.03 Record Reviews

DentaQuest has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards. The record assessment system addresses documentation of the items listed in the Patient Visit Data section above. Record reviews will be performed once every three years for providers treating more than 100 Louisiana Medicaid dental program patients annually.

In addition to its regular functions, the Utilization Oversight Program (UOP) establishes the ongoing monitoring of dental records as part of the benefit administration of the Louisiana Medicaid Program. The added level of review will ensure participating providers maintain proper patient records as required. Dental records reviews shall be conducted to ensure that primary dental providers provide high quality healthcare and that treatment is documented according to established Louisiana standards.

As noted, the Fraud Prevention and Recovery (“FPR”) department administers and oversees the UOP, working in concert with other departments including Complaints and Grievances, Quality Improvement and Utilization, Utilization Management, Credentialing and the Peer Review Committee.

Chart reviews offer insight into provider’s practice patterns and allow DentaQuest to identify deficiencies and suggest areas of improvement. The on-site review is a component of the Quality Improvement (QI) Program. All unsatisfactory findings are addressed through remedial action. The information will also be used as part of the re-credentialing process.

Treatment records are chosen randomly for periodic chart review. The request will clearly state the timeframe subject to the investigative process and the components of the enrollee record that is subject to review. Professional clinical staff will review the submitted documentation to assure and determine that the patient records meet acceptable standards of care.

FPR will determine whether any issues identified during a records review trigger a larger investigation into the provider’s treatment patterns. If so, a significant sample of records will be requested and reviewed by a clinical investigative team within FPR. If the issue requires a remedial action or corrective action plan, the provider will be notified in writing of the results of the review and have an opportunity to respond.

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At any time during the review or investigation, if a significant quality of care issue warrants an immediate action, an internal referral to the Peer Review Committee (PRC) can occur, which could result in a further investigation and/or a termination recommendation to the Credentialing Committee.

High level quality of care indicators including death cases are immediately investigated at the direction of the VP of Clinical Management, the VP of FPR, and the PRC. The Quality Improvement and Utilization Committee is a multidisciplinary committee responsible for quality activities and serves as a mechanism for communication and transparency within DentaQuest for quality management initiatives.

The Business Analytic Department produces Standard Deviation reports indicating a provider's or group's utilization deviates above the acceptable threshold from the mean (over-utilization) or Benchmark reports indicate utilization is below acceptable threshold (under-utilization). Thresholds for over-utilization and under-utilization will be determined by market.

FPR considers the following factors in preparing a recommendation for remedial action:

a. Over-utilization or under-utilization
b. Measure(s) or code group(s) identified
c. Variance from mean
d. Provider specialty

FPR prepares a recommendation for remedial action to include, but is not limited to:

a. Elevated requirements related to pre-payment review: Prior to rendering services from the code group identified, the provider is required to obtain authorization (if rendered in emergency, documentation of emergency is required for retro-active review);
b. Clinical Audits: Routine, focused clinical chart audits are conducted by the FPR;
c. Behavior Modification/Education: PRC notifies the provider in writing that the findings fall outside of acceptable range.

FPR will include in its recommendation the duration of the initial remedial action period. The recommendation is then routed through the PRC for approval.

If approved, a notification letter is mailed to the provider that indicates

a. Utilization that has been identified as aberrant;
b. Remedial action requirements;
c. Duration of remedial action period; and
d. Appeal rights

At the completion of the remedial action period, utilization data, authorization approval rates, chart audit results, and other relevant data and information are reviewed to determine whether additional remedial action is necessary.

If utilization remains outside of acceptable range, the previously established remedial action may be extended, or the provider may be referred to the PRC for additional consideration and action. If utilization falls within acceptable range, remedial action is discontinued, and provider/group is subject to standard monitoring.

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11.0 Credentialing

The purpose of the credentialing plan is to provide a general guide for the acceptance, monitoring, discipline and termination of Participating Providers. DentaQuest and LDH have the sole right to determine which dentists they shall accept and allow to continue as Participating Providers.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as they apply to dentistry. This is in full compliance with LDH guidelines. DentaQuest requires providers to submit a completed application, verification of information from primary and secondary sources, and confirmation of eligibility for payment under Medicaid.

DentaQuest accepts the Louisiana Standardized Credentialing Application Form or the CAQH Application. The Council for Affordable Quality Healthcare (CAQH) offers a single credentialing application and an online database that contains information necessary for insurance companies to credential a provider. For more information, visit the CAQH website at https://www.caqh.org/

DentaQuest has full discretion to accept or discipline participating Providers.

DentaQuest has the right to permit restricted participation by a dental office.

DentaQuest has the ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement. If the Credentials Committee recommends termination or restrictions on a participant, the Committee will offer the applicant an opportunity to appeal the decision. The applicant must request an appeal in writing and be received by DentaQuest within the timeframe allotted by DentaQuest.

Network Providers are recredentialed at least every 36 months pursuant to NCQA and Louisiana LDH guidelines.

Note: Additional information is available upon request by contacting DentaQuest's Provider Service Department at 800-508-6785.

12.00 Patient Recall System Requirement

Participating Providers are required to maintain proper patient records.

A. Recall System Requirement

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

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

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

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

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a DentaQuest approved outreach initiative, contact staff from these programs to ensure that scheduled appointments are kept.
- Have the Member contact the provider’s office prior to the appointment to confirm the time and place of the appointment.

B. Office Compliance Verification Procedures

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

• Emergent and Urgent care must be appointed within 24 hours and is defined as an unscheduled episode that requires a service to patients who present for immediate attention. The condition, if untreated, could place the patient’s health in jeopardy or cause serious consequences.

• DentaQuest ensures access to services for urgent dental and oral conditions or injuries based on the professional judgment of the member’s treating dentist, other dental professional, primary care provider or triage nurse who is trained in dental care and oral healthcare.

• Initial and recall routine treatment must be scheduled within 30 days of initial contact with the dentist’s office.

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

DentaQuest requires that a patient be seen within 45 minutes of arriving at the office or be given the opportunity to reappoint.

Participating Providers unable to meet these guidelines must refer the Member back to DentaQuest. DentaQuest will then be responsible for arranging needed care in the appropriate time frames. The number for Members to call for assistance is 800.685.0143 for Louisiana Medicaid.

Providers have the right to discontinue treatment of a Member with whom the practitioner feels he/she cannot establish or maintain a professional relationship. If a Provider is unable to maintain a professional relationship with a member, the Provider may terminate the relationship. Upon termination of the relationship by the Provider with the member, such termination reason should be provided to the member. Members that have been terminated by a Provider shall be referred back to DentaQuest by the Provider.

DentaQuest’s standard is that we support the provider/office policy in regard to dismissal of patients. We request they notify DQ of the dismissal with 5 days by sending our team (Louisianaproviders@dentaquest.com) a copy of the dismissal letter they have provided to the patient. DentaQuest will file it with Complaints Grievances & Appeals so they are aware and notify the Dental Home team that the member will need a new Dental Home assignment.

Members have information in the member handbook in regard to member responsibilities and how to locate a new dental home or receive assistance in finding a dentist, if they need it by calling DentaQuest.

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13.00 Radiology Requirements

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

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

Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required.

Postoperative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

14.00 Health Guidelines

In the event that Louisiana Medicaid rules or DentaQuest clinical criteria conflict with any of the following Periodicity Recommendations, then such Louisiana Medicaid rules or DentaQuest clinical criteria shall control.

15.00 Clinical Criteria

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances. Failure to submit required documentation when requesting authorization or prepayment review for a service may result in a denial by DentaQuest. All covered dental services must also be Medically Necessary as defined by LDH Rules. The clinical criteria presented in Section 15.01 through 15.16 are the criteria that DentaQuest dental benefit reviewers will use for making medical necessity determinations for those specific procedures. In addition, please review the general benefit limitations for certain dental procedures presented in Exhibits A, B, and E ~~& B~~. Exceptions to general benefit limitations may be made on an individual enrollee basis if medically necessary.

DentaQuest offers the following Value Added Benefits to it's Louisiana Medicaid Members:
EPSDT Under 21 Beneficiaries:

- Application of silver diamine fluoride when medically necessary (a safe, painless and effective liquid fluoride treatment that can slow tooth decay) Adult Denture Beneficiaries:
- Exams, X-rays and simple extractions. (NOTE: Extractions are subject to a $200 annual maximum)
- Cleaning and dental exam after visiting a dentist within 7 days of going to the hospital for non- traumatic dental care)

The clinical criteria presented in Section 15.01 through 15.16 are the criteria that DentaQuest dental benefit reviewers will use for making determinations for those specific value added services procedures.

D0150 exception: a recognized dental specialist within the same office (group) may perform a D0150 prior to the expiration of the three- year period.

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

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings. After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation. Please FAX this to 262-241-7150. DentaQuest will process urgent authorization requests as high priority. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

15.01 Criteria for Dental Extractions

Although all extractions must be medically necessary, not all procedures require authorization. Primary teeth that are being lost naturally must not be billed to Medicaid as an extraction. The extraction of primary teeth that are shown radiographically to be in the advanced stages of root resorption (more than ¾ of the root resorbed), i.e., exfoliating naturally, will not be paid unless warranted. The extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph must be taken as a diagnostic aid and as means of documentation. This radiograph must be submitted for pre-payment review. Written documentation of the reason for the extraction should be submitted.
Adult members have a value added benefit with DentaQuest which allows $200 per year maximum benefit for simple extractions.

A dual is an enrollee that has more than one insurance that requires review. When you submit for an enrollee that has dual coverage, it will be reviewed twice. First under the Primary plan and again under the Secondary plan.
The chart below identifies how submission of claims flow for DentaQuest adult Medicaid enrollees.

- **MCO Value Add** (DentaQuest administers Healthy Blue and Aetna Better Health) so DentaQuest will process those claims. However, if the member has one of the other MCO's you will need to work directly with that MCO for any value add dental benefits they may provide to their members.) Refer to the Healthy Blue and Aetna Better Health Office Reference Manuals (ORM) available on the secure provider portal under the documents tab.
- Louisiana Adult Medicaid (Denture) Refer to Exhibit B
- DentaQuest Value Add Refer to Exhibit C.~~B and page 61 of this ORM~~

Please check **Exhibit A** in the ORMs for benefits and you can see all benefits a member would have in the secured provider portal.

Documentation needed for authorization procedure:

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Diagnostic radiographs (strongly encourage digital) that are labeled Right (R) and Left (L) and the date the radiographs were taken, not submitted, showing clearly the adjacent and opposing teeth submitted for authorization (whether prior or post service) review; bitewings, periapical or panorex.
Treatment rendered under emergency conditions, when prior authorization (authorization prior to service) is not possible, will still require that

appropriate radiographs be submitted with the claim for review for payment. This is considered retro authorization.
Authorization for extraction of unerupted third molars:
Benefit review decisions for the authorization of unerupted third molar tooth extractions will be based upon medical necessity. Providers must use the most current and appropriate ADA Code(s) on Dental Procedures and Nomenclature (CDT) when submitting either a prior-authorization or retro-authorization/prepayment review for unerupted third molar extractions. •
The prophylactic removal of asymptomatic third molars or third molars exhibiting no overt clinical pathology is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.
• Documentation of medical necessity for oral surgery -evidence of diagnosed pathology or demonstrable need rather than anticipated future pathology.
a. Pathology
i. Provider must submit narrative and x-rays or photos describing pathology ii. Each tooth must show pathology iii. Symptomology or impactions without pathology may not be enough b. Demonstrable need
i. Clear and Concise Narrative describing need
- Clinical condition of the oral cavity and Per tooth narrative
- Describe symptoms and patient specific reasons why the procedure is needed
- Include any co-morbidities, contributing factors or considerations
- Describe any materials or extra time that is needed an why ii. Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)
- General Approval vs. Denial Guidelines

a. Probable Approval
i. Pathology = 1)
Nonrestorable Decay
2) Tooth erupting on an angle and impinging on 2nd molars
3) Recurrent Pericoronitis
4) Denti gerous Cyst or other growth
5) Internal or External Root Resorption
6) 3rd molar has over-erupted due to lack of opposing tooth contact ii. Demonstrable need

1. Pain with no pathology – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need b. Probable Denial
i. Impaction or Symptomology =
1. Impaction with no other

pathology

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

c. Denials

i. If administrative denial (e.g. lack of documentation) - Resubmit according to deficiencies noted in EOB

ii. If clinical denial:

1. Resubmit with documentation showing additional clinical evidence for extraction
2. Advise member service is not covered

a. Member can appeal following appeal process in member handbook

b. Provider and member may work out an out of pocket arrangement

- The removal of primary teeth whose exfoliation is imminent does not meet criteria • Impaction alone, absent pathology does not meet medical necessity criteria and therefore will not be authorized.
- For an extraction to be considered medically necessary an unerupted third molar must show pathology, or
- An unerupted third molar must demonstrate, by radiographic evidence, both an aberrant tooth position beyond normal variations and substantial (> 50%) root formation.
- Discomfort from natural tooth eruption not caused by pathology position will not qualify an unerupted third molar extraction for authorization.
- When at least a single third molar meets the criteria above, the DBPM may, at its complete clinical discretion and on a case-by- case basis, approve the extraction of additional unerupted third molar teeth to avoid risk from multiple exposures of the member to anesthesia.
- Routine incision and drainage is not considered a separate benefit if the extraction serves in this function
- Excision of lesion in conjunction with extraction is considered part of the extraction procedure.
- Excision of lesion that is not tooth related on same date of service requires a narrative and radiographic documentation of a hard tissue cyst/lesion or photographic evidence of soft tissue Alveoloplasty in conjunction with extractions require:
- A minimum of 4 teeth removed in a quadrant to qualify for the code
- Narrative supporting necessity for prosthetic placement
- Treatment notes must indicate that an Alveoloplasty is a separate surgical procedure from tooth removal.
- Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed.

Alveoloplasty not in conjunction with extractions require:

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

Surgical exposure of unerupted tooth to aid eruption or for orthodontic purposes:

- Radiographic evidence of impaction 1 year beyond normal age of eruption
- Tooth position that indicates tooth cannot erupt into the oral cavity
- Narrative of medical necessity
- Will be considered as part of another service if performed in conjunction with the removal of an adjacent unerupted tooth.

Tooth re-implantation:

- Must include a narrative indicating accident or trauma

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- Must include a periapical radiograph
- Can only be reviewed retrospectively.

15.02 Criteria for Crowns (lab processed)

Documentation needed for authorization of procedure:

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

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

Documentation required post service:

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

Criteria:

• In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations or where other restorative materials have a poor prognosis.

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

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

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

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

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- A request for a core build-up or a cast core must meet the following criteria:
- Presence of greater than 50% bone support
- Absence of sub-osseous decay and/or furcation involvement
- Absence of tooth structure to support crown
- Clinically acceptable root canal fill (post and core)
- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the tooth. Crowns on permanent teeth are expected to last a minimum of five years. Authorizations for crowns will not meet criteria if:
- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.

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

15.03 Criteria for Endodontics

Documentation needed for authorization of procedure:

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

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request. (this documentation is encouraged and not required)

Authorization for Pulpotomy must meet the following criteria:

- A pulpotomy is performed in a primary tooth with extensive caries but without evidence of radicular pathology when caries removal results in a carious or mechanical pulp exposure.
- A pulpotomy is indicated when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure. The objective is to maintain an asymptomatic tooth without clinical signs of sensitivity, pain, or swelling.

Authorization for Root canal therapy must meet the following criteria:

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

Authorizations for root canal therapy, root canal re-treatment, apicoectomies and apexification will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- Filling material not accepted by the Federal Food and Drug Administration. Other considerations:

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

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

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15.04 Criteria for Stainless Steel Preformed Crowns

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- Prophylactic use of stainless steel crowns is not a covered benefit.

Although prior authorization for Stainless Steel Crowns are not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre- operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the pathology or caries-detecting intra- oral photographs if radiographs could not be made for the ages of 5-20 on teeth D, E, F, G, N, O, P and Q.
- Copy of patient's dental record* with complete caries charting and dental anomalies
- Copy of detailed treatment plan.

Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

*Dental Records are regulated by the Rules of The Louisiana Board of Dentistry

Criteria:

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.
- Permanent molar teeth should have destruction to the tooth by caries or trauma and should involve four or more surfaces and/or two or more cusps.
- Permanent bicuspid teeth should have destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth should have destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary anterior teeth should have destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay.
- Primary molars should have destruction to the tooth by caries or
- trauma, and should involve two or more surfaces or substantial occlusal decay
- Primary teeth that have had a pulpotomy or pulpectomy performed.
- Extensive caries;
- Interproximal decay that extends in the dentin;
- Significant, observable cervical decalcification;
- Significant, observable developmental defects, such as hypoplasia and hypocalcification;
- Following pulpotomy or pulpectomy;
- Restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
- Fractured teeth.

Note: If a participating Provider fails to comply with the medical necessity guidelines for stainless steel crowns, DentaQuest will initiate corrective action, which may include imposition of prior authorization for this procedure.

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

- Should include a dated post-endodontic radiograph.

- Tooth should be filled sufficiently close to the radiological apex to ensurethat 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 theapex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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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. Criteria for treatment using stainless steel crowns willnot be met if:
- 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.
- Tooth has no apparent destruction due to caries or trauma.

15.05 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU)

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In emergencies) for members over the age of 5. Reimbursement for hospital call is limited to beneficiaries under the age of six, unless the child is physically, ~~or~~ mentally handicapped or an Adult Waiver member. DentaQuest performs these reviews as a courtesy to providers, since payment for all facility charges will be the responsibility of the appropriate managed care organization (MCO) or legacy Medicaid. Facility representatives will likely ask for this review and approval to submit to the MCO or legacy Medicaid.

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

- Provision of dental treatment in a hospital or SPU requires informed consent.
- Provision of dental treatment in OR for SPU requires prior authorization from

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

- Copy of the patient's dental record including health history, charting of the teeth and existing oral conditions*. A narrative is required when radiographs/full examination were unable to be performed.
- Diagnostic radiographs or caries-detecting intra-oral photographs.
- Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.
- Narrative describing medical necessity for OR.

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

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

"routinely" fail to submit radiographs or intra-oral photographs may be denied authorization for treatment

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The provider is responsible for choosing facilities/providers from Member's MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient's primary care provider.

DentaQuest would not recommend that providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.
Criteria:
In most situations, OR cases will be authorized for procedures covered by Louisiana Medicaid 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, oral, IM, or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
• Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
• Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during extensive dental procedures.
• Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.
• Patients requiring extensive dental procedures who have documentation ofpsychosomatic disorders that require special treatment.
• Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

15.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Diagnostic radiographs (strongly encourage digital) showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex. Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

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.
- Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth;

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- Missing two mandibular permanent anterior teeth; or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior).
- Medicaid may provide a partial denture in cases where the beneficiary has matured beyond the mixed dentition stage in the following cases:
- For adults a partial is covered when opposing arch has a full complete denture or when a complete opposing denture is being fabricated simultaneously • Missing three or more maxillary anterior teeth; EPSDT
- Missing two or more maxillary anterior teeth; EPSDT
- Missing three or more mandibular anterior teeth; ADULT
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant; EPSDT
- Missing at least 4 adjacent posterior permanent teeth in a single quadrant; ADULT
- when the prosthesis would restore masticatory function (third molars not considered for replacement);
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement); or
- Missing a combination of two or more anterior and at least one posterior
- Cast partials (D5213 and D5214) will be considered only for those beneficiaries who are 18 -20 years of age. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.
- 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 majority of teeth 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, a partial denture will be approved for benefits if it can be demonstrated that masticatory function has been severely impaired.

Authorizations for removable prosthesis will not meet criteria:

- If the patient has gingivitis or periodontal disease.
- 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 (lodge, gag reflex, potential for swallowing the prosthesis, severe disability).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or 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

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- and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Benefit Criteria

- If there is a pre-existing prosthesis, it must be at least 1 year old for members under 21 years of age or 8 years old for adult members, and unserviceable to qualify for replacement. • Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion.
- Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

After 6 months has elapsed:

- Adjustments will be reimbursed at one per calendar year per denture.
- A combination of 2 complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in an 8 year period as prior authorized. The 8 year period begins from the date the previous complete or partial denture for the same arch was delivered (adult members).
- Relines will be reimbursed once per denture every 12 months.
- If billing provider request a new complete or partial denture for the same arch within one year after delivery of reline, the reline fee will be deducted from the new prosthesis fee.
- Replacement of lost, stolen, or broken dentures less than 5 years of age for members under 21 or 8 years of age for adult members will not meet criteria for pre-authorization of a new denture with the exception of codes D5820 and D5821.
- 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.

Interruption of Treatment

The guidelines for the interruption of treatment apply to codes D5110, D5120, D5211, D5212, D5213, and D5214 ONLY. No other codes are eligible for payment under these guidelines. A provider must make every effort to deliver the denture. The provider must document in the member's treatment record all attempts to deliver the denture and the reasons the denture was not delivered. If a failure to deliver the denture was due to circumstances beyond the provider's control, such as if the member discontinues treatment or loses eligibility during the course of the construction of a denture, then under the interruption of treatment guidelines, the provider should not bill DentaQuest using the procedure code as originally preauthorized. Because the original procedure could not be completed, the case must be resubmitted to the Utilization Management department so the pre-authorization number can be reissued with the proper procedure code relating to the service attempted.

The provider will then be able to bill for that portion of the treatment that has been completed using the reissued procedure code and pre-authorization number. If the provider chooses to proceed with delivering the completed dentures to the member while they are no longer Medicaid eligible, the provider would be allowed to bill the member the remaining "contract rate"

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amount only under these circumstances. It is the responsibility of the provider to verify member eligibility with before the delivery of dentures.

An immediate denture that is not delivered cannot be reimbursed, nor will DentaQuest reimburse any payment under the interruption of treatment guidelines for an immediate denture. For the purpose of determining the amount the provider will be paid for interrupted services, the denture fabrication process is divided into four (4) stages:

- Impressions (initial impression, construction of custom dental impression tray and final impressions)
- Bite registration (wax try-in with denture teeth)
- Processing
- Delivery

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to DentaQuest. If treatment is interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made.

If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to DentaQuest.

If treatment is interrupted after completion of Stage 3 (Processing), 75% of the reimbursement fee will be paid upon submission of a color photo with the claim request.

15.07 Criteria for the Excision of Bone Tissue

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

CDT codes D7471, D7472, and D7473 are related to the removal of exostoses. These codes are subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant. Authorization requirements:

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

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

15.08 Criteria for the Determination of a Non-Restorable Tooth

For members under 21 years of age, application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

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

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

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- The tooth apex is surrounded by severe destruction of the bone.

15.09 Criteria for General Anesthesia, IV Sedation, and Anxiolysis *

Participating Providers who perform in office sedation must comply with the rules and regulations established by the Louisiana Board of Dentistry as they apply to sedation. Failure of Providers to provide compliant documentation of sedation in the patient record will result in corrective action and recoupment of monies paid for non-compliant sedation.

Providers rendering sedation services must have submit for the appropriate procedures being completed in that clinical session. If additional sedation time was used, the provider should submit the claim and sedation log post the clinical session for the level of sedation provided.
Documentation needed for authorization of procedure:

- Diagnostic radiographs or intra-oral photographs
- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.

- Treatment rendered under emergency conditions, when prior authorization is not possible, will still require submission of appropriate documentation with the claim for review for payment.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request. Criteria:
General anesthesia is reimbursable through the member's health plan. Requests for general anesthesia or IV sedation will be authorized in the same manner described above in section 15.05 for OR cases (for covered services) if any of the following criteria are met:
Extensive or complex oral surgical procedures such as:

- Unerupted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of 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 or intellectual disability) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

The use of sedation is not considered medically necessary when administered for the convenience of the provider. The use of anxiolysis non-intravenous conscious sedation intravenous (conscious sedation) moderate sedation should be a linear incremental progression decision and thought process, always beginning with the least possible sedative impact on the child that will allow successful treatment.
The goal of sedation is to:

- protect the patient's safety and welfare,
- minimize physical discomfort and pain;
- control anxiety,
- control behavior and/or movement to allow safe completion of the procedure(s)

The provider must return the patient to a state in which safe discharge from medical supervision is assured; (as determined by recognized criteria.)

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The objective of minimal and moderation sedation is to assure the patient is in a receptive state to enhance communication, cooperation, and attain optimal outcome of all procedure(s). The patient's chart must contain and document at a MINIMUM:

For each visit or appointment that sedation is employed
- The patient's presenting behavior or condition that requires sedation be employed
- Documentation that informed consent was obtained for all forms of sedation
- The time sedation began,
- Monitoring of patient's vital signs during sedation, and
- The time the sedation was discontinued

15.10 Criteria for Restraint of Pediatric and Special Needs Patients

Participating providers must comply with the rules of the Louisiana Board of Dentistry. Failure to comply may result in penalties up to, but not limited to, termination from participation as a provider with the DentaQuest Louisiana Medicaid Dental program:
- Purpose – The purpose of this rule is to recognize the unfortunate fact that pediatric and special needs patients may need to be restrained in order to prevent injury and to protect the health and safety of the patients, the dentist, and the dental staff. To achieve this, it will be important to build a trusting relationship between the dentist, the dental staff and the patient. This will necessitate that the dentist establishes communication with the patient and promote a positive attitude towards oral and dental health in order to alleviate fear and anxiety and to deliver quality dental care. Providers should always strongly consider a more minimally invasive treatment, such as Silver Diamine Fluoride.
- Training Requirement – Prior to administering restraint, the dentist must have received formal training at a dental school or during an American Dental Association accredited residency program in the methods of restraint described in below.
- Pre-Restraint Requirements
- Prior to administering restraint, the dentist shall consider:
- The need to diagnose and treat the patient.
- The safety of the patient, dentist, and staff; • The failure of other alternate behavioral methods.
- The effect on the quality of dental care.
- The patient's emotional development; and
- The patient's physical condition.
- Prior to administering restraint, the dentist shall obtain written informed consent from the parent or legal guardian and document such consent in the dental record
- Method of Restraint

The Physical Restraint or Medical Immobilization Method

This method may be used to partially or completely immobilize the patient for required diagnosis and/or treatment if the patient cannot cooperate due to lack of maturity, mental or physical disability, failure to cooperate after other behavior managements techniques have failed and/or when the safety of the patient, dentist, or dental staff would be at risk without using protective restraint. This method should only be used to reduce or eliminate untoward movement, protect the patient and staff from injury, and to assist in the delivery of quality dental treatment. If restraint or immobilization is deemed necessary, the least restrictive technique shall be used.

Use of this method shall not be used:
- With cooperative patients;

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- On patients who, due to their medical or systemic condition, cannot be immobilized safely;
- As punishment; or,
- Solely for the convenience of the dentist and/or dental staff
- Dental Hygienist and dental assistants shall not use the methods described in paragraph 4 by themselves but may assist the dentists necessary.
- The patient's record shall include:
- Written informed consent from parents or legal guardians;
- Type of method used;
- Reason for use of that method;
- Duration of method used; and,
- If restraint or immobilization is used, type of restraint or immobilization used
- Parents or legal guardians must be informed in advance of what treatment the patient will receive and why the use of restraints may be required. Parents or legal guardians shall be informed of the office policy concerning parental presence, the benefits and risks of parental presence, and of their opportunity to choose a different practitioner for the child if they are not comfortable with the office policy.
- Patents or legal guardians may not be denied access to the patient during treatment in the dental office unless the health and safety of the patient, parent or guardian, or dental staff would be at risk. The parent or guardian shall be informed of the reason they are denied access to the patient and both the incident of the denial and the reason for the denial shall be documented in the patient's dental record.

15.11 Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

- Diagnostic radiographs – periapicals or bitewings preferred.
- Copy of detailed treatment plan
- Intra-oral photographs clearly identifying the condition in cases of gingival hyperplasia
  Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

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

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arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
- Radiographic evidence of root surface calculus.
- Radiographic evidence of significant loss of bone support

Periodontal gingival flap surgical procedures must meet the following criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites after scaling and root planing
- Moderate to severe bone loss.

Gingivectomy procedures must meet the following criteria:

- Four (4) of Eight (8) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites of 5mm or greater after periodontal scaling and root planning
- Narrative of hyperplasia or hypertrophy associated with drug therapy, orthodontic treatment, hormonal disturbances, or congenital defects.
- Or, evidence of juvenile periodontitis.

15.12 Criteria for Minor Treatment to Control Harmful Habits

Fixed appliance therapy (D8220) treatments are covered services to control harmful habits. These treatment services include appliances for thumb sucking and tongue thrusting. Fixed indicates patient cannot remove appliance.
Procedure code D8220 requires prior authorization and must be submitted with the following documentation:
For approval of procedure code D8220, the following must apply:

- The child must be between the ages of 5 years through 8 years;
- The maxillary incisors (7, 8, 9 and 10) are actively erupting;
- The child still displays the destructive habit; and
- The child has evidenced a desire to stop the destructive habit.
- A duplicate set of pre-treatment study models or a duplicate set of diagnostic pre-treatment digital photographs that clearly demonstrate that there is existing damage to the permanent arch alignment being created by the thumb habit or tongue thrust. Radiographs, photographs, or study models will not be returned.
- A panoramic radiograph, if available.

The allowable fee includes records, adjustment appointments and any appliance repairs or replacements. The procedure can only be performed once in a lifetime.
15.13 Orthodontic Treatment Criteria
Orthodontic services are covered for Enrollees under 21. Orthodontic treatment for cosmetic purposes is not a covered benefit. The following outlines the policies and procedures associated with Orthodontics covered under the DentaQuest Louisiana Medicaid Dental program:

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1. Only dentists qualified under Chapter 3, Section 301, Parts (C) and (D) of the Rules promulgated by the Louisiana State Board of Dentistry as an approved specialty of "orthodontics and dentofacial orthopedics" are eligible to be reimbursed for Comprehensive

Orthodontic Services (procedure codes D8070, D8080, and D8090) in the Medicaid EPSDT Dental Program.
2. Providers should contact DentaQuest on each date of service to verify eligibility. Orthodontic services will only be reimbursed if rendered on a date when the Member is eligible.
3. Orthodontic cases must be submitted to DentaQuest for approval through one of the following means:
a. Submission of a duplicate set of diagnostic quality photographs (photographs will not be returned) to include:
i. Facial photographs (right and left profiles in addition to a straight on facial view) ii. Frontal view, in occlusion, straight on view iii. Frontal view, in occlusion, from a low angle iv. Right buccal view, in occlusion
v. Left buccal view, in occlusion vi. Maxillary occlusal view vii. Mandibular occlusal view
b. Submission of the alginate to OrthoCAD. OrthoCAD will enable dental Providers to send electronic models to DentaQuest electronically. OrthoCAD offers a low-cost alternative to submitting plaster models. The threat of broken, lost or otherwise compromised models is eliminated. All you need is a computer and Internet access.
c. In lieu of the above photographic requirement, DentaQuest will accept a duplicate set of diagnostic quality photographs of study models (photographs will not be returned) with the following parameters:
i. Occlusal view of the maxillary arch ii. Occlusal view of the mandibular arch iii. Right buccal view, in occlusion iv. Left buccal view, in occlusion
v. Facial view, straight on and low angle, in occlusion
vi. Posterior view of models in occlusion
d. DentaQuest will accept a duplicate case of the study models. Study models will not be returned.

Authorization
Duplicate photographs and all other applicable documentation sent to DentaQuest by the Provider via regular mail or OrthoCAD will not be returned to the dentist.
DentaQuest's orthodontic consultants utilize the photographs, OrthoCAD, radiographs and any applicable narrative to determine the medical necessity of the case.
Only eligible EPSDT Dental Program Members will be considered for orthodontic treatment.
Denials
If the case is denied, pre-determination denial letter will be sent to the Provider notifying them of the denied case within 24 hours of the denial determination. The Member will also receive written notification of the denial.
For denied cases, the models, radiographs, and any other accompanying materials will not be returned to the Provider. DentaQuest is required to keep the records in order to meet state record keeping requirements.

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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 billing only for the evaluation and diagnostic services rendered as part of the authorization submission. The date of service will be the date the treatment plan, radiographs and/or photos, records and diagnostic models were performed by the provider. Approvals

Comprehensive Orthodontia

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

- Providers will be reimbursed one of D8070, D8080 or D8090 at banding.
- Providers will be reimbursed no more than two D8999.

Submit a claim for D8070, D8080, or D8090 on the date of banding. This payment includes all orthodontic care necessary to complete treatment. Once the prior auth has been approved, all care is considered inclusive in the case rate, and no services will be reimbursed separately.

The first submission for D8999 must be after records was approved; then after banding (D8070, D8080 or D8090) and finally 90 days after banding and correspond with a date of service.

During comprehensive orthodontia treatment, Providers will ONLY be paid for one D8070, D8080,or D8090; two D8999's. All other services rendered during this time are considered an inclusive part of treatment and the case rate. Any other services will not be individually reimbursed. .

Members must be eligible for services on the date of service. If the child member loses eligibility during comprehensive orthodontic treatment, and chooses to continue treatment, it is the member's responsibility to pay for the continued treatment.
If the child member does not return for the completion of services and there is documented failure to keep appointments by the child member, or for any other reason that orthodontic care needs to be terminated, the orthodontic provider must submit the Orthodontic Termination of Care Submission Form to DentaQuest (form found on provider portal at (www.dentaquest.com) provideraccess.dentaquest.com
Recoupment of pre-paid fees will be determined by DentaQuest based upon the amount of treatment completed.
Louisiana Medicaid Members shall not be charged for missed appointments.

Eligible Members shall not be charged for broken brackets. Consideration for broken brackets is built into the orthodontic rate.
Orthodontic Continuation of Care (New Patient)
DentaQuest requires the following information for possible payment of continuation of care cases:

- Completed Orthodontic Continuation of Care Form.
- Completed ADA claim form listing services to be rendered.
- A copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.

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- If the Member is private pay or transferring from a commercial insurance program, original diagnostic photographs (or OrthoCAD equivalent), radiographs (optional).
- Release for treatment from previous orthodontic provider.

If the Member started treatment under commercial insurance or private pay or another State Medicaid program, we must receive the ORIGINAL photographs of the diagnostic models (or OrthoCAD), or radiographs (optional), banding date, and a detailed payment history.
It is the Provider's and Member's responsibility to get the required information. Cases cannot be setup for possible payment without complete information.

15.14 Criteria for Space Maintainers

Criteria for Unilateral Space Maintainer-Fixed
Space maintainers may be considered for payment if medically necessary for Members ages 0 through 20 based on the following criteria:
If the primary cuspids, primary first molars or primary second molars are missing or needs to be extracted due to pathology.

- Any stainless steel crown or orthodontic band that is part of the space maintainer is included in the space maintainer fee for the fixed space maintainer.
- Re-cementation for the first six months is included in the fee for the D1510 code. After six months, re-cementation is covered under the D1551/D1552/D1553 codes.
- The billing provider is responsible for replacement and recementation within the

first 12 months after placement of the space maintainer.

- Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids or primary second molars where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost.
Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing does not meet medical necessity for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the DentaQuest program. The same criteria are true in the lower arch as well.
If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss.
When there is a loss of a deciduous (primary) second molar and the position of the first permanent molar requires a distal shoe appliance, (D1575) to assure proper eruption, this code may be a covered benefit. Criteria that must be in the members chart to satisfy medical necessity include a diagnostic periapical image/xray of the edentulous space, and the unerupted first molar and appropriate narrative
Criteria for Fixed lingual Arch Space Maintainer-Fixed-Bilateral
Space maintainers may be considered for payment if medically necessary for Members ages 0 through 20 based on the following criteria:

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• Any associated stainless steel crown or orthodontic band that is part of the fixed space maintainer is included in the fee for the fixed space maintainer. A crown and a space maintainer cannot be submitted separately for payment if the space maintainer is attached to the crown.
• A lingual arch space maintainer does not meet medical necessity requirement when only primary centrals or laterals are missing. Primary cuspids, primary first molars or primary second molars must be missing or need to be extracted due to pathology.
• Repair or replacement of the appliance is not reimbursed before twelve months has lapsed since delivery of appliance.
• Re-cementation is included in the fee for the space maintainer for 12 months after placement. Following six months, re-cementation is covered under D1551, D1552 and D1553.

• Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost.
Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing is not necessary for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the DentaQuest program. The same is true in the lower arch as well. If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss. Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss qualifies as medically necessary or a unilateral space maintainer qualifies as medically necessary when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

15.15 Criteria for Occlusal Guards

An occlusal guard (D9944, D9945, D9946) is a removable appliance designed to minimize the effect of bruxism and other occlusal factors. To determine medical necessity the following criteria must be met:

- Occlusal guards require prior authorization.
- Occlusal guards do not meet medical necessary guidelines for patients with primary teeth.
- A narrative must be included on or with the claim defining why the occlusal guard is medically necessary. There must be clinical evidence and documentation (either a model or intraoral photograph if requested by DentaQuest) of unusual and significant wear and damage to the patient’s dentition. Occlusal guards or and device or appliance for the purpose of tooth whitening trays or athletic mouth guards are not considered medically necessary criteria.

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- The fee for the occlusal guard includes six months of follow up care, including adjustments.

15.16 Criteria for Frenectomy (Frenulectomy or Frenotomy)

Maxillary Frenectomy
Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Should not be rendered until the permanent incisors and cuspids have erupted and the diastema has had an opportunity to close naturally
- Digital photographs must be provided

Mandibular Labial Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below) • Digital photographs must be provided

Mandibular Lingual Frenectomy
Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Any available documentation from speech pathologists, pediatricians, oral surgeons, otolaryngologists, or lactation specialists should be provided

Criteria:

Maxillary frenectomy: Treatment should not be rendered until the permanent incisors and cuspids have fully erupted and any diastema has had an opportunity to close naturally. If orthodontic therapy is indicated, the frenectomy should be performed only after the diastema is closed as much as possible to achieve stable results.
Mandibular labial frenectomy: Treatment should be considered if the position of the mandibular labial frenum is causing inflammation, recession, pocket formation, and possible loss of the alveolar bone and/or tooth.
Mandibular lingual frenectomy: Treatment should be considered if the position of the lingual frenum is considered to be a contributing factor in malocclusion. A complete orthodontic evaluation, diagnosis and treatment plan are necessary prior to performing a frenectomy in this area. If it is suspected that the position of the lingual frenum is a contributing factor in altered speech patterns, a letter from a speech pathologist, pediatrician, oral surgeon, otolaryngologist and/or a lactation specialist must be included with the claim.

15.17 Criteria for Use of Silver Diamine Fluoride (SDF)

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

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is now a covered service for the Adult Waiver members 21 and up and as a value added benefit offered by DentaQuest for children under 21 when medically necessary. The medicament MUST be a product approved by FDA for use as a caries arresting medicament, and use must be consistent with the narrative in the descriptor of this code.

DentaQuest and the Louisiana Medicaid Dental Program advocate that the clinical indication for the use of Silver Diamine Fluoride is the management and arresting of significant areas and frequency or numbers of carious lesions.

SDF has been recommended for patients of any age with:

- Extreme caries risk
- Behavioral or medical management challenges
- Numerous carious lesions that are not treatable in one operative visit
- Difficult to treat lesions
- No access to comprehensive care

Administration of this benefit will be limited to four applications per tooth (limit 6 teeth per date of service) during enrollee's total period of eligibility, and there is a four-week period after application that restorative treatment is not a covered service on the same tooth that received SDF. This will assure the Silver Diamine Fluoride treatment and effect on the carious tooth structure has been able to approach desired completion. ADA CDT Code D1354 will not be covered on the SAME DAY as other fluoride applications. After a four-week interim period for completion of reaction, restorative treatment for carious teeth that received SDF., (based on medical necessity) will then be covered service(s).

In cases where loss of a sealant is a concern due to patient functional or dietary oral habit as well as faulty placement, an application of SDF (D1354) to a non-cavitated occ surface prior to placement of sealant (D1351) should lower risk of unprotected tooth surface experiencing carious activity. Sealant placement should be performed on a subsequent visit to SDF application.

15.18 Criteria for Teledentistry to FQHC Facilities ONLY

Hygienists can now provide limited, preventive services under the supervision of a federally qualified health center (FQHC) dentist that may be participating via telemedicine. The FQHC dentist must be licensed by the Louisiana Board of Dentistry.

These preventive services include:

- prophylaxis,
- x-rays,
- sealants, and
- fluoride varnish.

The dentist must remotely supervise and monitor the work of the hygienist and review the exam results and x-rays via a teledentistry connection to determine if further care is necessary before the patient is dismissed from the clinic on the day of treatment.

Place of service limitations

The provisions of these services is limited to the locations below:

- A public elementary or middle school in which 50 percent or more of the students are economically disadvantaged and is in a parish with a Health Professional Shortage Area (HPSA) score above 15; or
- A fixed clinic of an FQHC that does not have a dentist and is in a parish with a HPSA score above 15.

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Claim Guidelines

- Claims for these services must include the encounter code D0999 on the first claim line. The detail lines will include the procedure codes for the preventive services rendered by the hygienist and screening/assessment by dentist.
- The billing provider is the FQHC. The FQHC provider number and NPI must be included on the claim.
- The rendering provider is the supervising dentist. The dentist's provider number and NPI must be included on the claim.
- The telemedicine modifier 95 and place of service 02 are required on the claim.
- Place of service 10 used to identify services provided in a beneficiary's home cannot be used for these services.
- Reimbursement will be at the all-inclusive rate on file for the date of services.

16.00 General Definitions

The following definitions apply to this Office Reference Manual:

Adverse Action –
The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by Louisiana Department of Health, LDH), and the failure of DentaQuest to act within the timeframes for the resolution of grievances and appeals; and in a rural area with only one Dental Benefits Program Manager the denial of a enrollee's right to obtain services outside the provider network.
Agreement – The Provider Agreement between DentaQuest and Provider, including all attachments thereto.
Appeal Process – A formal process whereby an Enrollee exercises their right to contest an adverse benefit determination from DentaQuest.
Benefits – Shall mean the health care package of services developed by the Department of Health and which define the covered services available to enrollees. The Agreement focuses on Dental benefits although Benefits provided by the Enrollee's MCO are sometimes mentioned.
CAQH – Shall mean "The Council for Affordable Quality Healthcare," a nonprofit alliance of

health plans and trade associations, working to simplify the first steps of the provider credentialing and application data collection process.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Complaint– A Member's right to contest an action taken by DentaQuest or service provider that does not meet the definition of an adverse action.
Covered Service – A schedule of healthcare benefits and services required to be provided by the DBPM to Medicaid enrollees as specified under the terms and conditions of this Contract and the Louisiana Medicaid State Plan.

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Dental Benefits Program Manager (DBPM) – Dental Benefits Program Manager shall mean a contractor approved by the Louisiana Department of Health to provide dental benefits to enrollees in the Louisiana Medicaid Dental Program to the extent such services are covered by Louisiana Medicaid.
Dental Home – A dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, medically necessary, continuously accessible and coordinated way.
DentaQuest - Shall refer to DentaQuest USA Insurance CO., LLC.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) –A federally required **Medicaid benefit for individuals under the age of twenty**- one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) healthcare, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”.
Emergency Dental Condition – A dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of dentistry and medicine, could reasonably expect the absence of immediate dental attention to result in the following:

- Placing the health of the individual in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissue; or unusual swelling of the face or gums
Emergency Dental Services – Those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.
Enrollee – A Medicaid beneficiary who is currently enrolled in the dental benefit plan manager. For marketing and education materials, or other informational materials provided to the enrollee, the term “member” may be used.
Handicapping Malocclusion - For the purposes of determining eligibility under these regulations shall mean the presence of abnormal dental development that has at least one of the following:
• A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for

orthodontics. The condition must be non- responsive to medical treatment without orthodontic treatment.

• The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non- responsive to speech therapy without orthodontic treatment.

• Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.
Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating, chewing, or speaking. These

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conditions may be caused by other medical conditions in addition to the misalignment of the teeth. Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Health Insurance Portability and Accountability Act (HIPAA) federal standards for the privacy of individually identifiable health information, found at 45 CFR Part 164, Subpart E.

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

Managed Care Organization (MCO) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Department of Health as capable of providing medical, behavioral, and long-term care services in the Louisiana Medicaid Program.

Medically Necessary is defined by statute in LAC 50: I.1101 and shall describe a medical item or service that meets the criteria set forth in that statute.

Implementation of the term “medically necessary” is provided for in the Louisiana Medicaid rules, consistent with the statutory provisions, which control in case of ambiguity.

Medical Necessity Determination – A decision made regarding whether a requested medical item or service satisfies the definition of Medical Necessity contained in LAC 50: I.1101and these rules as defined herein.

Items or services that are not determined medically necessary shall not be paid for by DentaQuest.

Medical Necessity Guidelines/Clinical Criteria – Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

1. deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

2. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

Although a service may be deemed medically necessary, it doesn’t mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by- case basis.

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Member - refers to a Medicaid enrollee. For educational or other informational materials provided to the enrollee, the term “member” may be used.

Member Grievance - An expression of enrollee dissatisfaction about any matter other than an adverse benefit determination. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

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

Non-covered Benefit/Services – Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-participating Provider – An appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the DentaQuest for the delivery of covered services to the DentaQuest’s enrollees.

Provider or Participating Provider - Shall mean a provider, as defined herein and in the Louisiana Medicaid Rules, who has entered into a contract with DentaQuest.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

Prudent layperson– A person who possesses an average knowledge of dentistry and medicine.

Specialty Services – A dentist, whose practice is limited to a particular branch of dentistry or oral surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice.

Louisiana Medicaid – The program administrated by the Single State agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration waiver granted to the State of Louisiana.

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

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17.00 Confidentiality and Safeguards

DentaQuest

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

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

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

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

D. Privacy: Provider shall comply with the requirements of 45 C.F.R. Part 164, Subpart E, the HIPAA Privacy Rule. Among other things, the Privacy Rule requires a Provider to: •
Implement reasonable and appropriate safeguards to ensure that it uses and discloses Protected Health Information only for treatment, payment, health care operations, and other purposes permitted or required by the Privacy Rule.

- Establish appropriate mechanisms to limit the use or disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use or disclosure.
- Provide an appropriate level of training to its staff and employees regarding HIPAA/HITECH-related policies, procedures, enrollee rights and penalties upon hire and at appropriate intervals thereafter and maintain appropriate documentation of such training. • Engage its business associates in business associate agreements that meet the requirements of the Privacy and Security Rules.
- Make Protected Health Information available in accordance with 45 C.F.R. § 164.524; amend Protected Health Information and incorporate any amendments as required by 45 C.F.R. § 164.526; and account for disclosures of patients' Protected Health Information as required by 45 C.F.R. § 164.528.
- Provide patients with a notice of privacy practices in the manner and with the content required by the Privacy Rule, including information that informs patients of their privacy rights.

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18.00 Sensitive Information

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

A. Alcohol and Drug Abuse Treatment Records:

When Provider receives information subject to the Federal Substance Abuse Rule (42 C.F.R. Part 2), Provider must comply with 42 C.F.R. Part 2, which generally prohibits re-disclosure without written consent. Note that a general written consent (including a HIPAA-compliant authorization) is not sufficient. In most cases, the following statement will accompany these records and must be included with such records when Provider discloses them to another party: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42
C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B. Federal Tax Information (FTI):

Any FTI made available to Provider must be used only for the purpose of carrying out the provisions of this Agreement. Federal Tax Information contained in such material shall be treated as confidential and shall not be divulged or made known in any manner to any person except as may be necessary in the performance of this Agreement. Inspection by or disclosure to anyone other than an officer or employee of the Provider is strictly prohibited. Failure to comply with federal regulations regarding SSA, Medicaid, CHIP, and Substance Abuse, FTI, and PHI data may result in criminal and civil fines and penalties.

APPENDIX A – ADDITIONAL RESOURCES

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at to access the following resources:
DentaQuest Louisiana Medicaid Specific Forms:

- **COC Form 425**
- **Consent Form**
- **DentaQuest Provider Appeal Form • Hospital Readiness Form**
- **LA Medicaid Authorized Rep Form**
- **LA Medicaid Authorized Rep Form_SP**
- **LA Medicaid Member Grievance Appeal Form**
- **LA Medicaid Member Grievance Appeal Form SP DentaQuest General Forms:**
- **ADA Dental Claim Form**
- **ADA Claim Form Instructions**
- **Authorization for Dental Treatment**
- **DentaQuest EFT Form**
- **Initial Clinical Exam**
- **Medical and Dental History**
- **OrthoCad Submission Form**
- **Recall Examination**

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- **Request for Transfer of Records**
- **Standard Updates Form**

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

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within 30 days will belimited to the allowance for a full mouth series.

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

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

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

Reimbursement for procedures provided outside the recommended age limits require documentation of medical necessity such as in a form of a narrative. Note: Preventive and EPSDT services

shall be covered.

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

Diagnostic								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D0120	periodic oral evaluation - established patient	3-20		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.		**$27.24**
D0140	limited oral evaluation- problem focused	0-20		No	No	This procedure is not payable when submitted in conjunction with routine dental services on the same date of service.		**$15.00**
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.		**$48.49**
D0150	comprehensive oral evaluation - new or established patient	3-20		No	No	One of (D0150) per 3 years by the same provider. Not reimbursable if (D0120, D0145, D0150) was paid within 6 months by the same provider.		**$47.37**
D0210	intraoral - complete series of radiographic images	0-20		No	No	One of (D0210, D0330) per 12 Month(s) Per Provider OR Location.		**$60.17**
D0220	intraoral - periapical first radiographic image	0-20		No	No	**One (D0220) Per Day Per Patient.**		**$14.69**

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Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D0230	intraoral - periapical each additional radiographic image	0-20		No	No			**$12.42**

Diagnostic								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D0240	intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240) per day Per ProviderOR Location.		**$20.41**
D0272	bitewings - two radiographic images	0-20		No	No	One per (D0272) in 12-month per day Per Provider OR Location. Not allowed within 12-month period (D0210)		**$21.43**
D0330	panoramic radiographic image	3-20		No	No	One per (D0210, D0330) per 12 months per Provider OR Location.		**$57.05**
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	No	Two per (D0350) per day Per Provider OR Location.		**$27.42**
D0470	Diagnostic casts	0-20		No	No			**$47.44**
D0473	accession of tissue, gross and microscopic exam	0-20		No	No			**$74.49**
D0474	accession of tissue, gross and microscopic exam (surgical)	0-20		No	No			**$77.09**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

All sealants must be performed on a single date of service unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services. Sealants are available for the occlusal surface only. If there are circumstances that would not allow sealants to be applied in this manner, the contraindication(s) must be documented in the beneficiary's treatment record. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

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

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

Note: Preventive and EPSDT services shall be covered.

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

Preventative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D1110	prophylaxis - adult	12-20		No	No	One of (D1110, D1120) per 6 Month(s) Per patient. D4355 not allowed within 12 months **following D1110, or D1120.**		**$48.01**
D1120	prophylaxis - child	0-11		No	No	One of (D1110, D1120) per 6 Month(s) Per patient. D4355 not allowed within 12months **following D1110, or D1120.**		**$35.02**
D1206	topical application of fluoride varnish	0-5		No	No	One of (D1206, D1208) per 6 Month(s) Per Provider **OR Location.** .		**$24.29**
D1208	topical application of fluoride - excluding varnish	0-15		No	No	One of (D1206, D1208) per 6 Month(s) Per Provider **OR Location.**		**$19.77**
D1351	**sealant - per tooth**	**0-9**	**Teeth , 3, 14, 19, 30,**	**No**	**No**	**One of (D1351) per 24 Month(s) Per patient per tooth.**	-	**$25.51**
D1351	**Sealant – per tooth**	**0-15**	**Teeth 2, 15, 18, 31**	**No**	**No**	**One of (D1351) per 24 Month(s) Per patient Per tooth.**		**$25.51**
D1351	Sealant – per tooth	0-16						

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Preventative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D1510	space maintainer-fixed, unilateral- per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$151.52**
D1516	Space maintainer, fixed, bilateral, maxillary	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$206.61**
D1517	Space maintainer, fixed, bilateral, mandibular	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$206.61**
D1551	Recementation of space maintainer maxillary	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$38.77**
D1552	Recementation of space maintainer mandibular	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$38.77**
D1553	Recement or rebond unilateral space maintainer – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$38.77**
D1556	Removal of fixed unilateral space maintainer – per quadrant	0-20	**Per Quadrant (10, 20, 30, 40, LL, LR, - UL, UR)**	No	No	Not allowed by same provider/location/group that placed space maintainer.		**$38.26**
D1557	Removal of fixed bilateral space maintainer – maxillary	0-20		No	No	Not allowed by same provider/location/group that placed space maintainer.		**$38.26**
D1558	Removal of fixed bilateral space maintainer – mandibular	0-20		No	No	Not allowed by same provider/location/group that placed space maintainer.		**$38.26**
D1575	distal shoe space maintainer – fixed – unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No			**$151.52**

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Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty-six months, unless there is recurrent decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. For providers to bill for a complex occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

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

Note: Preventive and EPSDT services shall be covered.

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

Unusual anatomic tooth/ surface combinations may include but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration. Cases may be considered with photographic evidence of extent of decay or restoration.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2140	Amalgam - one surface, primary	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$64.79**
D2140	Amalgam - one surface, primary	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$64.79**
D2140	Amalgam - one surface, permanent teeth only	0-20	Teeth 1 – 32	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$74.79**
D2140	**Amalgam – One surface – Primary teeth only**	**0-20**	**Teeth A-C, H-M, R-T**	**No**	**No**	**One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.**		**$64.79**

Restorative

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Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D2150	Amalgam - two surfaces, primary	0-4	**Teeth D, E, F, G, N, O, P, Q**	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$82.14**
D2150	Amalgam - two surfaces, primary	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$82.14**
D2150	Amalgam – two surfaces primary teeth only	0-20 ~~5-20~~	**Teeth A-C, H-M, R-T.**	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$82.14**
D2150	Amalgam - two surfaces, permanent teeth only	0-20	**Teeth 1 - 32, with two surfaces combo EXCEPT MO or DO**	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$92.14**
D2150	Amalgam - two surfaces, permanent teeth only	0-20	**Teeth1-32 . with two surfaces combo MO or DO.**	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$117.14**
D2160	amalgam - three surfaces, primary	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$99.48**
D2160	amalgam - three surfaces, primary	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$99.48**
D2160	**Amalgam – three surfaces, primary**	**0-20**	**Teeth A-C, H-M, R-T**	**No**	**No**	**One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.**		**$99.48**
D2160	amalgam - three surfaces, permanent teeth only	0-20	Teeth 1 -32 with three surfaces comboexcept OBL	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$131.48**

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D2160	amalgam - three surfaces, permanent teeth only	0-20	Teeth 1 - -32 with three surfaces combo OBL.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$109.48**
D2161	amalgam - four or more surfaces, permanent	0-20	**Teeth 1 - -32**	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$131.48**
D2330	resin-based composite - one surface, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$76.01**

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Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2330	resin-based composite - one surface, anterior	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$76.01**
D2330	**Resin-based composite – One surface, anterior**	**0-20**	**Teeth C, H, M, R**	**No**	**No**	**One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.**		**$76.01**
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6-11, 22-27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$96.01**
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$94.38**
D2331	**resin-based composite - two surfaces, anterior**	**5-20**	**Teeth D, E, F, G, N, O, P, Q**	**Yes**	**No**	**One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.**	**Preoperative X-Rays**	**$94.38**
D2331	Resin-based composite – two surfaces, anterior	0-20	Teeth C, H, M, R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$94.38**

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D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6-11, 22-27 with two surfaces, combo except MI or DI.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$124.38**
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6-11, 22-27 with two surfaces, combos MI or DI only.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$126.38**
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No **No**	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$114.79**
<u>D2332</u>	**Resin-based composite – three surfaces, anterior**	**5-20**	**Teeth D, E, F, G, N, O, P, Q**	**Yes**		**One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.**	**Preoperative X-Rays**	**$114.79**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth C, H, M and R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$114.79**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6-11 and 22-27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$151.79**
D2335	resin-based composite - fouror more surfaces or involving incisal angle (anterior)	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$143.87**
D2335	**Resin-based composite – four or more surfaces or involving incisal angle (Anterior)**	**5-20**	**Teeth D, E, F, G, N, O, P, Q**	**Yes**	**No**	**One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.**	**Preoperative X-Rays**	**$143.87**
D2335	resin-based composite - fouror more surfaces or involving incisal angle (anterior)	0-20	Teeth C, H, M and R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$143.87**

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D2335	resin-based composite - fouror more surfaces or involving incisal angle (anterior)	0-20	Teeth 6-11 and 22- 27 with four surfaces including surface I	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$198.87**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2390	resin-based composite crown, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$210.70**
D2390	resin-based composite crown, anterior	5-20	Teeth D, E, F, G, N, O, P and Q	Yes ~~No~~	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	**Preoperative X-Rays**	**$210.70**
D2390	**resin-based composite crown, anterior**	**0-20**	**Teeth C, H, M and R**	**No**	**No**	**One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.**	-	**$210.70**
D2390	resin-based composite crown, anterior	0-20	Teeth 6-11 and 22-27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$305.70**
D2391	resin-based composite - one surface, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$64.79**
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1-5, 12-21 and 28-32	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$74.79**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D2392	resin-based composite - two surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S, T	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$82.14**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with two surfaces combo except MO or DO	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$92.14**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with two surfaces combo MO or DO	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$117.14**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$99.48**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with three surfaces combo except OBL	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$131.48**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with three surfaces combo of OBL	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$109.48**
D2394	resin-based composite - fouror more surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$117.34**

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D2394	resin-based composite - four or more surfaces, posterior - permanent teeth only	0-20	Teeth 1- 5, 12 -21, 28-32.	No	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$131.48**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Restorative								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	No	Not allowed within 12 months of initial placement.		**$50.00**
D2930	prefabricated stainless-steel crown - primary tooth	0-4	Teeth D, E, F, G, N, O, P and Q	No	No			**$127.54**
D2930	prefabricated stainless-steel crown - primary tooth	**5-20**	**Teeth D, E, F, G, N, O, P and Q**	Yes	No		Preoperative X-Rays	**$127.54**
D2930	prefabricated stainless-steel crown - primary tooth	0-20	Teeth A, B, C, H, I, J, K, L, M, R, S andT	No	No			**$127.54**
D2931	prefabricated stainless-steel crown-permanent tooth	0-20	Teeth 1-32	Yes	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	pre-operative x-ray(s)	**$202.03**
D2932	prefabricated resin crown	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (, D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$165.80**
D2932	**prefabricated resin crown**	**5-20**	**Teeth D, E, F, G, N, O, P and Q**	**Yes**	**No**	**One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.**	**Preoperative X-Rays**	**$165.80**
D2932	prefabricated resin crown	0 - 20	Teeth C, H, M, R, 6-11 and 22-27	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$165.80**
D2933	prefabricated stainless-steel crown with resin window	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$168.86**
D2933	**prefabricated stainless-steel crown with resin window**	**5-20**	**Teeth D, E, F, G, N, O, P and Q**	**Yes**	**No**	**One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.**	**Preoperative X-Rays**	**$168.86**
D2933	prefabricated stainless-steel crown with resin window	0 - 20	Teeth C, H, M, and R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$168.86**

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D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$218.86**

D2934	**prefabricated esthetic coated stainless steel crown - primary tooth**	**5-20**	**Teeth D, E, F, G, N, O, P and Q**	**Yes**	**No**	**One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.**	**Preoperative X-Rays**	**$218.86**

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D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	Teeth C, H, M, and R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$218.86**
D2950	core buildup, including any pins when required	0 - 20	Teeth 2 -15 and 18-31	No	No	Not allowed with D2954		**$128.56**
D2951	pin retention - per tooth, in addition to restoration	0 - 20	Teeth 2 -5, 12 -15, 18- 21, 28-31.	No	No	Only allowed one per 12 months with D2160or D2161 same tooth.		**$35.20**
D2954	prefabricated post and corein addition to crown	0 - 20	Teeth 2 -15 and 18-31	No	No	Not allowed with D2950	Inpatient Records	**$160.70**
D2999	unspecified restorative procedure, by report	0 - 20	Teeth 1 – 32, A-T	Yes	No		Preoperative	**By Report**

Reimbursement includes local anesthesia.

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

A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.Filling material not accepted by

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

Complete root canal therapy includes, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

Note: Preventive and EPSDT services shall be covered.

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

Endodontics

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D3110	Pulp cap - direct (excluding final restoration	0-20	Teeth 1 - 32	No	No	**Not allowed with(D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330) for the same toothor same date of service or provider or location.**		**$38.26**

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D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D3220) per 24 month(s) Per Tooth		**$94.38**
D3220	**Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament**	**5-20**	**Teeth D, E, F, G, N, O, P and Q**	**Yes**	**No**	**One of (D3220) per 24 month(s) Per Tooth**	**Preoperative X-Rays**	**$94.38**
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A, B, C, H, I, J, K, L, M, R, S andT	No	No	One of (D3220) per 24 month(s) Per tooth per provider or Location.		**$94.38**
D3222	Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development	0-20	Teeth 2-15 and 18-31	No	No	One of (D3222) per 24 month(s) Per tooth per provider or Location.	pre-operative x-ray(s)	**$94.38**

Endodontics

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth A, J, K, T	No	No			**$152.03**
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$336.71**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D3320	Endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$395.37**
D3330	Endodontic therapy, molar tooth (excluding final restoration)	0 - 20	Teeth 2, 3, 14, 15, 18, 19, 30 and 31	Yes	No	One of (D3330) per 1Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$474.45**
D3346	Retreatment of previous root canal therapy-anterior	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. Not billable by same provider/location that performed original root canal therapy	pre-operative x-ray(s)	**$391.29**
D3352	Apexification/recalcification - interim medication replacement	0 - 20	Teeth 2-15 and 18-31	Yes	No	**This service is limited to a maximum of three (3) treatments per tooth with the root canal being billed separately. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal.**	pre-operative x-ray(s)	**$121.42**
D3410	Apicoectomy - anterior	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No		pre-operative x-ray(s)	**$323.44**
D3430	Retrograde filling - per root	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No	**Only approved in conjunction with code D3410.**	pre-operative x-ray(s)	**$128.56**
D3999	Unspecified endodontic procedure, by report	0 - 20	Teeth 1 – 32, A - T	Yes	No		Narrative of medical necessity pre- operative x-ray(s)	**By Report**

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Note: Preventive and EPSDT services shall be covered. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Reviewed**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Narrative of medical necessity and preoperative X-Rays	**$295.38**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One D4341 per 12 month(s) per quadrant, Not allowed within 12 month(s) of D1110 or D1120	Narrative of medical necessity and preoperative X-Rays necessity	**$128.56**
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	0 - 20		Yes	No	One of (D4355) per 12 months per patient. Not allowed within 12 month(s) of D1110 or D1120. Not allowed with D0150.		**$86.73**
D4999	unspecified periodontal procedure, by report	0 - 20		Yes	No		**Narrative of medical necessity and preoperative X-Rays**	**By Report**

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A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impairthe general health of the member (medically necessary). Payment for dentures includes any necessary adjustments during the six (6) month period following delivery and routine post-delivery care, or relines during the twelve (12) month period following delivery and routine post- delivery care..

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth;
- Missing two mandibular permanent anterior teeth; or • Missing three or more permanent teeth in the same arch (of which at least one must be anterior).

Medicaid may provide a partial denture in cases where the beneficiary has matured beyond the mixed dentition stage in the following cases:

- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement);
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement); or
- Missing a combination of two or more anterior and at least one posterior

Cast partials (D5213 and D5214) will be considered only for those beneficiaries who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic imagesshould verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

BILLING AND REIMBURSEMENT FOR COMPLETE OR PARTIAL REMOVABLE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ONTHE INSERTION/CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

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

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

Prosthodontics, removable								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D5110	complete denture - maxillary	0 - 20	Per Arch (01, UA)	Yes	No	One of (D5110/D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)	$495.00
D5120	complete denture - mandibular	0 - 20	Per Arch (02, LA)	Yes	No	One of (D5120/D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	$495.00

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Prosthodontics, removable								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D5130	Immediate denture - maxillary	0 - 20	Per Arch (01, UA,)	Yes	No	One of (D5130, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$495.00**
D5140	Immediate denture - mandibular	0 - 20	Per Arch (02, LA)	Yes	No	Per patient. One of (D5130, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$495.00**
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0 - 20	Per Arch (01, UA)	Yes	No	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$470.00**
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0 - 20	Per Arch (02, LA)	Yes	No	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$470.00**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	18 – 20	Per Arch (01, UA)	Yes	No	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$688.00**
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	18 – 20	Per Arch (02LA)	Yes	No	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$688.00**
D5511	Repair broken complete denture base, mandibular	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$125.00** ***Total of $175.00 limit in denture repairs per arch per year***
D5512	Repair broken complete denture base, maxillary	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$125.00** ***Total of $175.00 limit in denture repairs per arch per year***

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D5520	replace missing or broken teeth - complete denture (each tooth)	0 - 20	Teeth 2-15 and 18-31	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Prosthodontics, removable								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D5611	Repair resin denture base, partial denture, mandibular	0 - 20		No	No	Not covered within 12 monthsof placement.	pre-operative x-ray(s)	**$125.00** ***Total of $175.00 limit in denture repairs per arch per year***
D5612	Repair resin partial denture base, maxillary	0 - 20		No	No	Not covered within 12 monthsof placement.	pre-operative x-ray(s)	**$125.00** ***Total of $175.00 limit in denture repairs per arch per year***
D5630	repair or replace broken retentive/clasping materials per tooth	0 - 20	Teeth 1-32	No	No	Not covered within 12 monthsof placement.	pre-operative x-ray(s)	**$119.00** **Total of $175.00 limit in denture repairs per arch per year**
D5640	replace broken teeth-per tooth	0 - 20	Teeth 2-15 and 18-31	No	No	Not covered within 12 monthsof placement. .	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00** **Total of $175.00 limit in denture repairs per arch per year**
D5650	add tooth to existing partial denture	0 - 20	Teeth 2-15 and 18-31	No	No	Not covered within 12 months of placement. -	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00** **Total of $175.00 limit in denture repairs per arch per year**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D5660	add clasp to existing partial denture	0 - 20	Per Quadrant (10, 20, 30, 40, LL, LR,UL, UR)	No	No	Not covered within 12 monthsof placement.	pre-operative x-ray(s)	**$119.00** **Total of $175.00 limit in denture repairs per arch per year**

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ʳrosthodontics, removable								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D5750	reline complete maxillary denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$238.00**
D5751	reline complete mandibular denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement. **Allowed once per60 months.**	pre-operative x-ray(s)	**$238.00**
D5760	reline maxillary partial denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement. **Allowed once per 60 months.**	pre-operative x-ray(s)	**$208.00**
D5761	reline mandibular partial denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement**. Allowed once per60 months.**	pre-operative x-ray(s)	**$208.00**
D5820	Interim partial denture - maxillary	6 – 20		Yes	No	One of (D5820) per 12 Month(s) Per patient	pre-operative x-ray(s)	**$375.00**
D5821	Interim partial denture - mandibular	6 – 20		Yes	No	One of (D5821) per 12 Month(s) Per patient	pre-operative x-ray(s)	**$375.00**
D5899	unspecified removable prosthodontic procedure, by report	0 - 20		Yes	No		pre-operative x-ray(s)	**By report**
D5986	Fluoride gel carrier	0 - 20	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative x-ray(s)	**$98.76**

Prosthodontics, fixed								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D6241	Pontic – porcelain fused to predominantly base metal	0 - 20	Teeth 7, 8, 9, and 10	Yes	No	One of (D6241) per 60 Month(s) Per patient Must be billed with D6545, no other missing maxillaryteeth. Replaces one maxillary anterior tooth.	pre-operative x-ray(s)	**$486.69**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D6545	Retainer - cast metal for resin bonded fixed prosthesis	0 - 20	Teeth 6, 7, 8, 9, 10 and 11	Yes	No	One of (D6545) per 60 Month(s) per patient per tooth, Maximum oftwo D6545 per 60 Month(s).	pre-operative x-ray(s)	**$394.35**
D6999	Unspecified fixed prosthodontic procedure, by report	0 - 20	Teeth 1 - 32	Yes	No		narrative of medical necessity	**By Report**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

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

Note: Preventive and EPSDT services shall be covered.

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

Oral and Maxillofacial Surgery								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Reviewed**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D7111	extraction, coronal remnants – primary 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	No			**$64.79**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth 1 – 32, 51 – 82, A -T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS,TS	No	No			**$79.07**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10-20	A, B, C, H, I, J, K, L, M, R,S, T	Yes	No		Preoperative X-Ray	**$79.07**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10-20	Teeth 1 – 32, 51 – 82, D,E, F, G, N, O, P, Q, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS,OS, PS, QS, RS, SS, TS	No	No			**$79.07**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Oral and Maxillofacial Surgery								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Reviewed**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1-20	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	No		pre-operative x-ray(s)	**$130.09**
D7220	removal of impacted tooth-soft tissue	1-20	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	No		pre-operative x-ray(s)	**$150.50**
D7230	removal of impacted tooth-partially bony	1-20	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	No		pre-operative x-ray(s)	**$200.26**
D7240	removal of impacted tooth-completely bony	1-20	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	No		pre-operative x-ray(s)	**$245.62**
D7241	removal of impacted tooth-completely bony	1-20	Teeth 1 -32, 51–82,,A –T, and AS-TS	Yes	No		pre-operative x-ray(s)	**$278.04**
D7250	surgical removal of residual tooth roots (cutting procedure)	1-20	Teeth 1 - 32, 51 – 82, A-T, and AS - TS	Yes	No	Will not be paid to the dentist or group that removed the tooth.	pre-operative x-ray(s)	**$144.38**

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D7270	tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	1-20	Teeth 1-32	Yes	No	Includes splinting and/or stabilization.	narr. of med. necessity, post-op x-ray(s)	**By Report Maximum Fee $255.05**

Oral and Maxillofacial Surgery								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Reviewed**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D7280	Surgical access of an unerupted tooth	1-20	Teeth 2- 15 and 18-31	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$229.57**
D7283	placement of device to facilitate eruption of impacted tooth	1-20	Teeth 2- 15 and 18-31	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$245.90**
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		**Pathology report & Preoperative X-Rays**	**By Report Maximum Fee $194.88**
D7286	incisional biopsy of oral tissue-soft	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Pathology report	**152.54**
D7291	transeptal fiberotomy, by report	1-20	Per Arch (01, 02,LA, UA)	Yes	No			**$152.03**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$140.29**
D7510	incision and drainage of abscess - intraoral soft tissue	1-20	Teeth 1 – 32, 51-82, A-T, AS-TS	Yes	No		narrative of medical necessity	**$109.68**
D7880	occlusal orthotic device, by report	1-20	Per Arch (01, 02,LA, UA)	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$461.69**
D7910	suture small wounds up to 5 cm	1-20		Yes	No		Narrative of Medical Necessity	**$140.80**

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Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D7961	Buccal/labial frenectomy – (frenulectomy) separate procedure not incidental to another procedure	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Diagnostic photographs **&** **Narrative of medical necessity**	**$211.21**
D7962	Lingual frenectomy (frenulectomy)	1-20	(02, 30, 40)	Yes	No	One of (D7962) per lifetime	**Pathology Report**	**$211.21**
D7997	appliance removal (not by dentist who placed appliance), includes removalof archbar	1-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)	**By Report Maximum Fee $240.00**
Oral and Maxillofacial Surgery								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D7999	unspecified oral surgery procedure, by report	1-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)	**By Report**

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

DentaQuest Louisiana Medicaid Members age 20 and under may qualify for orthodontic care under the program. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 1/2 years of age, treatment must be initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.

Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member; or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.

Comprehensive orthodontic treatment is approved by DentaQuest only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy: other severe craniofacial deformities that result in age appropriate surgical cases as determined by a DentaQuest Dental Consultants.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, DentaQuest will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for 180 days.

Providers are reminded that DentaQuest reimbursement is payment in full for the procedure code. To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. DentaQuest reimbursement includes the brackets/appliance.

During comprehensive orthodontia treatment, Providers will ONLY be paid for one D8070, D8080,or D8090; two D8999's. All other services rendered during this time are considered an inclusive part of treatment and the case rate. Any other services will not be individually reimbursed.

DentaQuest requires the following information for possible payment of continuation of care cases: Completed Orthodontic Continuation of Care Form, completed ADA claim form listing services to be rendered and 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 photographs (orOrthoCAD equivalent), radiographs (optional). Release for treatment from previous orthodontic provider.

Interceptive Orthodontic treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.

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Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Orthodontics								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D8010	Interceptive orthodontic treatment of the primary dentition	0-20		No	Yes	1 per lifetime (D8010, D8020)	Diagnostic digital photographs, study models, pan **or** peri xrays, narr/treatment plan	**Maximum Fee $438.00**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Orthodontics								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D8020	Interceptive orthodontic treatment of the transitional dentition	0-20		No	Yes	1 per lifetime (D8010, D8020)	Diagnostic digital photographs, study models, pan or peri xrays, narr/treatment plan	**Maximum Fee $438.00**
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.	Diagnostic digital photographs, study models, pan or peri xrays, narr/treatment plan	**Maximum Fee $4,182.00**
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.	Diagnostic digital photographs, study models, pan or peri xrays, narr/treatment plan	**Maximum Fee $4,281.00**
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.		**Maximum Fee $4,515.00**
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	5-8		No	Yes	**Harmful Habits Only**	Pano, narrative of medical necessity and photographs	**534.71**
D8999	unspecified orthodontic procedure, by report	0-20		No	Yes		**Narrative**	**By Report**

Reimbursement includes local anesthesia. General Anesthesia and IV Sedation will be reviewed on a case by case basis for medical necessity. Note: Preventive and EPSDT services shall be covered.

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

Adjunctive General Services								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	No	One of (D9110) per Day(s) Per Provider OR Location. Two of (D9110) per 12 month(s) Per Provider OR Location. Not allowed with any other services other than x-rays and emergency exams.		**$58.67**
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	No	Not allowed in conjunction with, D9239,D9243, or D9248.		**$36.73**
D9239	Intravenous moderate conscious sedation/analgesia – first 15 minutes	0-20		Yes	No	Not allowed in conjunction with, D9230, orD9248.	narrative of medical necessity	**$109.17**
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15-minute increment	0-20		Yes	No	Not allowed in conjunction with, D9230, orD9248. Three (3) of D9243 per day, per patient.	narrative of medical necessity	**$73.98**
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes	No	One of (D9230, D9248, D9243) per 1 Day(s) Per patient. Not allowed with D9230, D9239, D9243, or D9920.	narrative of medical necessity	**$125.45**
D9420	hospital or ambulatory surgical center call	0-5		No	No	One of (D9420) per 6 month(s) Per patient.		**$106.18**
D9420	hospital or ambulatory surgical center call	6-20		No	Yes	One of (D9420) per 6 month(s) Per patient.	narrative of medical necessity.Must document physical or mental disability	**$106.18**
D9440	office visit - after regularly scheduled hours	0-20		Yes	No		narrative of medical necessity	**$81.01**
D9920	behavior management, by report	0-7		No	No	- **Four of (D9920) per 12 Month(s) per Provideror Location**		**$70.10**
D9920	behavior management, by report	8-20		Yes	No	**Four of (D9920) per 12 Month(s) perProvider or Location**	narrative of medical necessity	**$70.10**

D9944	Occlusal guard – hard appliance, full arch	13-20	Per arch 01, 02, LA, UA	Yes	No	**One of (D9944, D9945, D9946) per patientper 12 months. Narrative req. for PPR.**	narrative of medical necessity	**$285.08**
D9945	Occlusal guard – soft appliance, full arch	13-20	Per arch 01, 02, LA, UA	Yes	No	**One of (D9944, D9945, D9946) per patientper 12 months. Narrative req. for PPR.**	narrative of medical necessity	**$285.08**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D9946	Occlusal guard – hard appliance, partial arch	13-20	Per arch 01, 02, LA, UA	Yes	No	**One of (D9944, D9945, D9946) per patientper 12 months. Narrative req. for PPR.**	narrative of medical necessity	**$285.08**
D9951	occlusal adjustment – limited	13-20		Yes	No		narrative of medical necessity	**$87.24**
D9999	unspecified adjunctive procedure, by report	0-20		Yes	No		narrative of medical necessity	**By Report**

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Exhibit B Benefits Covered for Adult Denture Program

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

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within 30 days will be limited to the allowance for a full mouth series.

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

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

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

Reimbursement for procedures provided outside the recommended age limits require documentation of medical necessity such as in a form of a narrative. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D0150	comprehensive oral evaluation - new or established patient	21-99		No	No	. Limited to one (1) every eight (8) yearsby the same provider, facility, or groupfor the Adult Denture Program. Must include D0210, D0240, or D0330 as well as a treatment plan for the Adult Denture Program procedures scheduled for the member by any provider. Also denied in conjunction with denture repair or reline.		**$47.37**
D0210	intraoral - complete series of radiographic images	21-99		No	No	Limited to one (1) every eight (8) yearsby the same provider, facility, or groupfor the Adult Denture Program.		**$60.49**

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre- Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D0240	intraoral - occlusal radiographic image	21-99		No	No	Limited to one (1) every eight (8) years bythe same provider, facility, or group for theAdult Denture Program.		**$20.41**

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D0330	panoramic radiographic image	21-99		No	No	Limited to one (1) service every eight (8) years by the same provider, facility, or group for Adult Denture Program.		**$57.05**

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments during the six (6) month period following delivery and routine post-delivery care or relines during the twelve (12) month period following delivery and routine post-delivery care

Prosthodontics, removable								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D5110	complete denture - maxillary	21-99		No	Yes	One of (D5110, D5130, D5211) per 96 Month(s) per patient.	pre-operative x-ray(s)	**$495.00**
D5120	complete denture - mandibular	21-99	Per Arch (02, LA)	No	Yes	One of (D5120, D5140, D5212) per 96 Month(s) per patient.	pre-operative x-ray(s)	**$495.00**
D5130	Immediate denture - maxillary	21-99	Per Arch (01, UA)	No	Yes	One of (D5130, or D5140) per	pre-operative x-ray(s)	**$495.00**
D5140	Immediate denture - mandibular	21-99	Per Arch (02, LA)	No	Yes	One of (D5130, or D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)	**$495.00**
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	21-99	Per Arch (01, UA)	No	Yes	One of (D5211, or D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)	**$470.00**

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Exhibit B Benefits Covered for Adult Denture Program

BILLING AND REIMBURSEMENT FOR COMPLETE OR PARTIAL REMOVABLE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ONTHE INSERTION/CEMENTATION DATE.

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

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

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Authorization Required	Benefit Limitations	Documentation Required	Fee Rate
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	21-99	Per Arch (02, LA)	No	Yes	One of (D5212, or D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)	**$470.00**
D5511	Repair broken complete denture base, mandibular	21-99	Teeth 17 - 32	No	Yes	. Not covered within 12 months of placement.	pre-operative x-ray(s)	**$125.00 to a maximum of $175.00**
D5512	Repair broken complete denture base, maxillary	21-99~~9~~	Teeth 1 - 16	No	Yes	Not covered within 12 months of placement	pre-operative x-ray(s)	**$125.00 to a maximum of $175.00**
Prosthodontics, removable								
D5520	replace missing or broken teeth - complete denture (each tooth)	21-99	Teeth 2-15 and 18-31	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00 Total of $175.00 limit in denture repairs per arch**
D5611	Repair resin partial denture base, mandibular	21-99		No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$125.00**
D5612	Repair resin partial denture base, maxillary	21-99		No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$125.00**

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Exhibit B Benefits Covered for Adult Denture Program

D5630	repair or replace broken retentive/clasping materials per tooth	21-99	Teeth 1-32	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$119.00**
D5640	replace broken teeth-per tooth	21-99	Teeth 2-15 and 18-31	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00** **Total of $175.00 limit in denture repairs per arch**
D5650	add tooth to existing partial denture	21-99	Teeth 2-15 and 18-31	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**1st Tooth = $65.00 Each additional tooth = $33.00** **Total of $175.00 limit in denture repairs per arch**
D5660	add clasp to existing partial denture	21-99		No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$119.00 to maximumof $175.00**
D5750	reline complete maxillary denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	**$238.00**
D5751	reline complete mandibular denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	**$238.00**
D5760	reline maxillary partial denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	**$208.00**
D5761	reline mandibular partial denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	**$208.00**
D5899	unspecified removable prosthodontic procedure, by report	21-99		No	Yes		pre-operative x-ray(s)	**By Report**

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Exhibit ~~B~~ C Value Added Benefits for Adults

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

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

Note: Extractions are subject to a $200 annual maximum

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

Oral and Maxillofacial Surgery								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D0150	**comprehensive oral evaluation - new or established patient**	**21-99**		**Yes**	**No**	**One of (D0150) per 1 year Per Provider ORLocation for Value Added Services**		**$47.37**
D0210	**intraoral - complete series of radiographic images**	**21-99**		**No**	**No**	**One of (D0210) per 12 Month(s) Per Provider OR Location for Value Added Services**		**$60.49**
D0240	**intraoral - occlusal radiographic image**	**21-99**		**No**	**No**	**Two per (D0240) per dayPer Provider OR Location for Value Added Services.**		**$20.41**
D0330	**Panoramic radiographic image**	**21-99**		**No**	**No**	**One per (D0330) per 12 months per Provider OR Location for Value Added Services.**		**$57.05**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21-99	Teeth 1 - 32, 51 – 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No			$~~79.07~~130.09

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D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21-99	Teeth 1 - 32, 51 – 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS,	Yes	No	Includes cutting of gingiva and bone, removal of toothstructure and closure.	pre-operativex-ray(s)	130.09

Exhibit ~~C~~D - Value Added Benefits – EPSDT Under 21 Dental Program

Value Added Benefits								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D1354	Interim caries arresting medicament application	0-20	Teeth 1-32, 51-82, A-T, AS-TS	No	No	Four applications per tooth (limit 6 teeth per date of service)		**$15.00**

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Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

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

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within 30 days will be limited to the allowance for a full mouth series.

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

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

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

Reimbursement for procedures provided outside the recommended age limits require documentation of medical necessity such as in a form of a narrative.

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

Dental Services for the Adult Waiver Program

DIAGNOSTIC PROCEDURE CODES

Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D0120	Periodic oral examination – Patient of Record	21-99		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.		27.24
D0140	Limited oral evaluation- problem focused	21-99		No	No	This procedure is not payable when submitted in conjunction with routine dental services on the same date of service.		15.00
D0150	Comprehensive oral examination – New Patient Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 3 years) only.	21-99		No	No	Limited one (D0150) per 3 years by the same provider. Not reimbursable if (D0120, D0145, D0150) was paid within 6 Month(s) by the same provider.		47.37

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

D0210	Intraoral - Complete series of radiographic images	21-99		No	No	One of (D0210, D0330) per 12 Month(s) Per Provider OR Location.		60.17
D0220	Intraoral – Periapical first radiographic image	21-99		No	No	One (D0220) Per Day Per Patient		14.69
D0230	Intraoral – Periapical each additional radiographic image	21-99		No	No			12.42
D0240	Intraoral - Occlusal radiographic image	21-99		No	No	Two of (D0240) per day Per ProviderOR Location.		20.41
D0272	Bitewings – 2 Radiographic images	21-99		No	No	One per (D0272) in 12-month per day Per Provider OR Location. Not allowed within 12-month period (D0210)		21.43
D0330	Panoramic radiographic image	21-99		No	No	One per (D0210, D0330) per 12 months per Provider OR Location.		57.05
D0350	Oral/facial images	21-99		No	No	Two per (D0350) per day Per Provider OR Location.		27.42
D0470	Diagnostic casts	21-99		No	No			47.44
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	21-99		No	No			74.49
D0474	Accession of tissue, gross and microscopic examination; including assessment of surgical margins for presence of disease, preparation and transmission of written report	21-99		No	No			77.09

Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

Dental Services for the Adult Waiver Program **PREVENTIVE PROCEDURE CODES**								
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D1110	Prophylaxis – Adult	21-99		No	No	This procedure is reimbursable once per 6 months. More frequent prophylaxis may be approved if deemed medically necessary.		48.01
D1208	Topical application of fluoride – excluding varnish	21-99		No	No			19.77
D1354	Interim caries arresting medicament application – per tooth	21-99	Teeth 1-32	No	No	Reimbursed per tooth every 6 months. Total of four (4) times per lifetime of the tooth, which may be increased if the caries risk remains high or extremely high. Limited to Silver Diamine Fluoride.		15.00

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty-six months, unless there is recurrent decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. For providers to bill for a complex occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore thebuccal or lingual pit in addition to the occlusal surface.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration

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

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

Unusual anatomic tooth/ surface combinations may include but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration.

Cases may be considered with photographic evidence of extent of decay or restoration.

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

Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

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

			21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.					
D2150	Amalgam- two surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		117.14

Dental Services for the Adult Waiver Program RESTORATIVE PROCEDURE CODES								
Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D2140	Amalgam-one surface only posterior - permanent teeth	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		74.79
D2150	Amalgam-two surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20,	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		92.14

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

D2160	Amalgam-three surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		131.48
D2160	Amalgam- three surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		109.48
D2161	Amalgam-four surfaces posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		131.48
D2330	Resin-based composite, one surface, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		96.01
D2331	Resin-based composite, two surfaces, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo except MI or DI.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		124.38

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Exhibit EE Covered Benefits for Adult Waiver Members ~~Benefits Covered for Adults with Intellectual or Developmental Disabilities~~ 21 and Over

D2331	Resin-based composite, two surfaces, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo of MI or DI.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		126.38
D2332	Resin-based composite, three surfaces, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		151.79
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with four surfaces, including the surface I.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		198.87
D2390	Resin-based composite crown, anterior	21-99	Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		305.70
D2391	Resin-based composite - one surface, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		74.79
D2392	Resin-based composite, two surfaces, posterior	21-99	Tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32.	No	No	One of (D2330, D2331, D2332, 2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		82.14

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

D2392	Resin-based composite, two surfaces, posterior	21-99	Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		92.14
D2392	Resin-based composite - two surfaces, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		117.14
D2393	Resin-based composite - three surfaces, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		131.48
D2393	Resin-based composite - three surfaces, posterior	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		$109.48

Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

D2394	Resin-based composite - four surfaces, posterior - permanent teeth only	21-99	Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		131.48
D2920	Recement crown	21-99	Tooth number 1 through 32	No	No	Not allowed within 12 months of initial placement		50.00
D2931	Prefabricated stainless steel crown, permanent tooth	21-99	Tooth number 1 through 32	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		152.03
D2931	Prefabricated stainless steel crown - permanent teeth only	21-99	Tooth number 1 through 32	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		202.03
D2932	Prefabricated resin crown (permanent teeth)	21-99	Tooth number 6 through 11 and 22 through 27	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		165.80
D2950	Core buildup, including any pins, in addition to crown	21-99	Tooth number 2 through 15 and 18 through 31.	No	No	Not allowed with D2954		128.56
D2951	Pin retention, per tooth, in addition to restoration	21-99	Tooth number 2 through 5; 12 through 15; 18 through 21; and 28 through 31	No	No	Only allowed one per 12 months with D2160 or D2161 same tooth.		35.20
D2954	Prefabricated post and core in addition to crown	21-99	Tooth number 2 through 15 and 18 through 31	No	No	Not allowed with D2950	Inpatient Records	160.70
D2999	Unspecified restorative procedure, by report	21-99	Tooth number 1 through 32.	No	No		Preoperative	*****

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

Reimbursement includes local anesthesia.

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

A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

Complete root canal therapy includes, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

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

Dental Services for the Adult Waiver Program

ENDODONTIC PROCEDURE CODES

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D3110	Pulp cap – direct (excluding final restoration)	21-99	Tooth number 1 through 32.	No	No	Not allowed with(D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330) for the same tooth or same date of service or provider or location.		38.26
D3220	Therapeutic pulpotomy (excluding final restoration)- permanent teeth only	21-99	Tooth number 1 through 32.	Yes	No	One of (D3220) per 24 month(s) Per Tooth	pre-operative x-ray(s)	94.38
D3222	Partial pulpotomy for apexogensis	21-99	Tooth numbers 2 through 15 and18 through 31	No	No	One of (D3222) per 24 month(s) Per tooth per provider or Location.	pre-operative x-ray(s)	94.38
D3310	Endodontic Therapy, anterior (excluding final restoration)	21-99	Tooth number 6 through 11 and 22 through 27.	Yes	No	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	336.71

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Exhibit E~~E~~ Covered Benefits for Adult Waiver Members ~~Benefits Covered for Adults with Intellectual or Developmental Disabilities~~ 21 and Over

D3320	Endodontic Therapy, bicuspid (excluding final restoration)	21-99	Tooth number 4, 5, 12, 13, 20, 21, 28 and 29.	Yes	No	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	395.37
D3330	Endodontic Therapy, molar (excluding final restoration)	21-99	Tooth number 2, 3, 14, 15, 18, 19, 30 and 31.	Yes	No	One of (D3330) per 1Lifetime Per patient per tooth.	pre-operative x-ray(s)	474.45
D3346	Retreatment of previous root canal therapy, anterior	21-99	Tooth number 6 through 11 and 22 through 27.	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. Not billable by same provider/location that performed original root canal therapy	pre-operative x-ray(s)	391.29
D3352	Apexification/recalcification, Interim Medication Replacement	21-99	Tooth number 2 through 15 and 18 through 31.	Yes	No	This service is limited to a maximum of three (3) treatments per tooth with the root canal being billed separately. A time period of 90 days must elapse betweent he final D3352 treatment and start of the root canal.	pre-operative x-ray(s)	121.42
D3410	Apicoectomy, anterior	21-99	Tooth number 6 through 11 and 22 through 27.	Yes	No		pre-operative x-ray(s)	323.44
D3430	Retrograde filling, per root	21-99	Tooth number 6 through 11 and 22 through 27.	Yes	No	Only approved in conjunction with code D3410	pre-operative x-ray(s)	128.56
D3999	Unspecified endodontic procedure, by report	21-99	Tooth number 1 through 32.	Yes	No		Narrative of medical necessity pre- operative xray(s)	*****

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

Note: Preventive and EPSDT services shall be covered.

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

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

Dental Services for the Adult Waiver Program

PERIODONTIC PROCEDURE CODES

Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	21-99	Oral cavity designator 10, 20, 30 and 40.				Narrative of medical necessity and preoperative X-Rays	295.38
D4341	Periodontal scaling and root planning, four or more teeth per quadrant	21-99	Oral cavity designator 10, 20, 30 and 40.			One D4341 per 12 month(s) per quadrant. Not allowed within 12 month(s) of D1110 or D1120	Narrative of medical necessity and preoperative X-Rays necessity	128.56
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	21-99				One of (D4355) per 12 months per patient. Not allowed within 12 month(s) of D1110 or D1120. Not allowed with D0150.	Narrative of medical necessity and preoperative X-Rays necessity	86.73
D4999	Unspecified periodontal procedure, by report	21-99					Narrative of medical necessity and preoperative X-Rays	*****

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments during the six (6) month period following delivery and routine post-delivery care, or relines during the twelve (12) month period following delivery and routine postdelivery care.

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth;

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- Missing two mandibular permanent anterior teeth; or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior).

Medicaid may provide a partial denture in cases where the beneficiary has matured beyond the mixed dentition stage in the following cases:

- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement);
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement); or
- Missing a combination of two or more anterior and at least one posterior

Cast partials (D5213 and D5214) will be considered only for those beneficiaries who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic imagesshould verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

BILLING AND REIMBURSEMENT FOR COMPLETE OR PARTIAL REMOVABLE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ONTHE INSERTION/CEMENTATION DATE.

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

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

Dental Services for Adult Waiver Progam
REMOVABLE PROSTHODONTIC PROCEDURE CODES

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D5110	complete denture, maxillary	21-99	Per Arch (01, UA)	No	Yes	One of (D5110, D5130, D5211) per 96 Month(s) per patient.	pre-operative x-ray(s)	495.00

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D5120	complete denture, mandibular	21-99	Per Arch (02, LA)	No	Yes	One of (D5110, D5130, D5211) per 96 Month(s) per patient.	pre-operative x-ray(s)	495.00
D5130	Immediate denture, maxillary	21-99	Per Arch (01, UA,)	No	Yes	One of (D5110, D5130, D5211) per 96 Month(s) per patient.	pre-operative x-ray(s)	495.00
D5140	Immediate denture, mandibular	21-99	Per Arch (02, LA)	No	Yes	One of (D5130, or D5140) per 96 Month(s) Per patient.	pre-operative x-ray(s)	495.00
D5211	Maxillary partial denture, resin base (including retentive/clasping materials, rests and teeth)	21-99	Per Arch (01, UA)	No	Yes	One of (D5211, or D5213) per 96 Month(s) Per patient.	pre-operative x-ray(s)	470.00
D5212	Mandibular partial denture, resin base (including retentive/clasping materials, rests and teeth)	21-99	Per Arch (01, UA,)	No	Yes	One of (D5212, or D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)	470.00
D5511	Repair broken complete denture base, mandibular	21-99	Per Arch (01, UA)	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	125.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5512	Repair broken complete denture base, maxillary	21-99		No	Yes	One of (D5212, or D5214) per 96 Month(s) Per patient.	pre-operative x-ray(s)	125.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*

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D5520	Replace missing or broken tooth, complete denture/per tooth	21-99	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	65.00/33.00 1st Tooth = $65.00; Each additional tooth = $33.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5611	Repair resin denture base, partial denture, mandibular	21-99		No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	125.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5612	Repair resin partial denture base, maxillary	21-99		No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	125.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*

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D5630	Repair or replace broken retentive/clasping materials, partial denture – per tooth	21-99	This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.	No	Yes	Not covered within 12 months of placement	pre-operative x-ray(s)	119.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5640	Replace missing or broken teeth, partial denture, per tooth	21-99	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	**No**	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	65.00/33.00 1st Tooth = $65.00; Each additional tooth = $33.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*

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Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D5650	Add tooth to existing partial denture .	21-99	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	65.00/33.00 *1st Tooth = $65.00; Each additional tooth = $33.00* *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5660	Add clasp to existing partial denture – per tooth	21-99	This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.	No	Yes	Not covered within 12 months of placement.	pre-operative x-ray(s)	119.00 *Total of $175.00 limit in denture repairs per arch, see manual for details.*
D5750	Reline complete maxillary denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	238.00
D5751	Reline complete mandibular denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	238.00
D5760	Reline maxillary partial denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	208.00
D5761	Reline mandibular partial denture (indirect)	21-99		No	Yes	Not covered within 12 months of placement. Maximum 2 per 8 years.	pre-operative x-ray(s)	208.00
D5899	Unspecified removable prosthodontic procedure, by report	21-99		No	Yes		pre-operative x-ray(s)	*****

Dental Services for the Adult Waiver Progam
FIXED PROSTHODONTIC PROCEDURE CODES

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

D6241	Pontic - porcelain fused to predominantly base metal	21-99	Tooth number 7, 8, 9, and 10.	Yes	No	One of (D6241) per 60 Month(s) Per patient Must be billed with D6545, no other missing maxillary teeth. Replaces one maxillary anterior tooth.	pre-operative x-ray(s)	486.69
D6545	Retainer - cast metal for resin bonded fixed prosthesis	21-99	Tooth number 6, 7, 8, 9, 10 and 11.	Yes	No	One of (D6545) per 60 Month(s) per patient per tooth, Maximum of two D6545 per 60 Month(s).	pre-operative x-ray(s)	394.35
D6999	Unspecified, fixed prosthodontic procedure, by report	21-99		Yes	No			*****

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

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

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

Dental Services for the Adult Waiver Progam **ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES**

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Exhibit EE~~E~~ Covered Benefits for Adult Waiver Members ~~Benefits Covered for Adults with Intellectual or Developmental Disabilities~~ 21 and Over

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.				Preoperative X-Ray	79.07
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No		pre-operative x-ray(s)	130.09
D7220	Removal of impacted tooth – soft tissue	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No		pre-operative x-ray(s)	150.50
D7230	Removal of impacted tooth – partially bony	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No		pre-operative x-ray(s)	200.26
D7240	Removal of impacted toothcompletely bony	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No		pre-operative x-ray(s)	245.62
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No		pre-operative x-ray(s)	278.04

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

D7250	Surgical removal of residual tooth roots (cutting procedure)	21-99	Tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Yes	No	Will not be paid to the dentist or group that removed the tooth.	pre-operative x-ray(s)	144.38
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	21-99	Oral cavity designator 01 and 02.	Yes	No	Includes splinting and/or stabilization.	narr. of med. necessity, post-op x-ray(s)	***** Maximum Fee $255.05
D7280	Surgical access of an unerupted tooth	21-99	Tooth number 2 through 15; and 18 through 31.	Yes	No		narr. of med. necessity, pre-op x- ray(s)	229.57
D7283	Placement of device to facilitate eruption of impacted tooth	21-99	Tooth number 2 through 15; and 18 through 31.	Yes	No	For Medicaid approved comprehensive orthodontic cases only	narr. of med. necessity, pre-op x- ray(s)	245.90
D7285	Biopsy of oral tissue – hard (bone, tooth)	21-99	oral cavity designator 01, 02, 10, 20, 30 or 40.	Yes	No		Pathology report & Preoperative X-Rays	***** Maximum Fee 194.88
D7286	Biopsy of oral tissue - soft (all others)	21-99	oral cavity designator 01, 02, 10, 20, 30 and 40.	Yes	No		Pathology report	152.54
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	21-99	oral cavity designator 01 and 02	Yes	No	For Medicaid approved comprehensive orthodontic cases only.		152.30
D7310	Alveoloplasty in conjunction with extractions – per quadrant	21-99	oral cavity designator 10, 20, 30 and 40.				narr. of med. necessity, pre-op x- ray(s)	140.29
D7510	Incision and drainage of abscess – intraoral soft tissue	21-99	for Tooth number 1 through 32.				narr. of medical necessity	109.68

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Exhibit E~~E~~ Covered Benefits for Adult Waiver Members ~~Benefits Covered for Adults with Intellectual or Developmental Disabilities~~ 21 and Over

	D7880	Occlusal orthotic device, by report	21-99	oral cavity designator 01 and 02.				narr. of med. necessity, pre-op x-ray(s)	461.69
	D7910	Suture of recent small wounds up to 5 cm	21-99					Narrative of Medical Necessity	140.80
	D7961	Buccal / Labial Frenectomy (Frenulectomy)	21-99	oral cavity designator 01, 02, 10, 20, 30 and 40.				Diagnostic photographs & Narrative of medical necessity	211.21
	D7962	Lingual Frenectomy (Frenulectomy)	21-99				One of (D7962) per lifetime	Pathology Report	211.21
	D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	21-99	oral cavity designator 01 and 02				narr. of med. necessity, pre-op x- ray(s)	***** Maximum Fee $240.00
	D7999	Unspecified oral surgery procedure, by report	21-99					narr. of med. necessity, pre-op x- ray(s)	*****

DentaQuest Louisiana Medicaid Members over age 20 with Intellectual or Developmental Disabilities may qualify for orthodontic care under the program. Such treatment may continue as long as the enrollee remains eligible.

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Exhibit E Covered Benefits for Adult Waiver Members 21 and Over

Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member; or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.

Comprehensive orthodontic treatment is approved by DentaQuest only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy: other severe craniofacial deformities that result in age appropriate surgical cases as determined by a DentaQuest Dental Consultants.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, DentaQuest will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for 180 days.
Providers are reminded that DentaQuest reimbursement is payment in full for the procedure code. To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. DentaQuest reimbursement includes the brackets/appliance.
During comprehensive orthodontia treatment, Providers will ONLY be paid for one D8090. All other services rendered during this time are considered an inclusive part of treatment and the case rate. Any other services will not be individually reimbursed.

DentaQuest requires the following information for possible payment of continuation of care cases: Completed Orthodontic Continuation of Care Form, completed ADA claim form listing services to be rendered and 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 photographs (or OrthoCAD equivalent), radiographs (optional). Release for treatment from previous orthodontic provider.

Interceptive Orthodontic treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.

Dental Services for the Adult Waiver Progam
ORTHODONTIC PROCEDURE CODES

Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prepayment Review**	**Pre-Auth Required**	**Benefit Limitations**	**Documentation Required**	**Fee Rate**
D8090	Comprehensive orthodontic treatment of the adult dentition	21-99		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient	Diagnostic digital photographs, study models, pan or peri xrays, narr/treatment plan	***** Maximum Fee $4,515.00

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Exhibit EE Covered Benefits for Adult Waiver Members Benefits Covered for Adults with Intellectual or Developmental Disabilities 21 and Over

Reimbursement includes local anesthesia. General Anesthesia and IV Sedation will be reviewed on a case by case basis for medical necessity.

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

Dental Services for the Adult Waiver Progam
ADJUNCTIVE GENERAL SERVICES PROCEDURE CODES

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D9110	Palliative (emergency) treatment of dental pain	21-99		No	No	One of (D9110) per Day(s) Per Provider OR Location. Two of (D9110) per 12 month(s) Per Provider OR Location. Not allowed with any other services other than xrays and emergency exams.		58.67
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	21-99		No	No	Not allowed in conjunction with, D9239,D 9243, or D9248.		36.73
D9239	Intravenous moderate conscious sedation/analgesia – first 15 minutes	21-99		Yes	No	Not allowed in conjunction with, D9230, orD 9248.	narrative of medical necessity	109.17
D9243	Intravenous moderate conscious sedation/analgesia – each additional 15 minute increment	21-99		Yes	No	Not allowed in conjunction with, D9230, orD 9248. Three (3) of D9243 per day, per patient.	narrative of medical necessity	73.98
D9248	Non-intravenous conscious sedation	21-99		Yes	No	One of (D9230, D9248, D9243) per 1 Day(s) Per patient. Not allowed with D9230, D9239, D9243, or D9920.	narrative of medical necessity	125.45
D9420	Hospital call	21-99		No	Yes	One of (D9420) per 6 month(s) Per patient.	narrative of medical necessity. Must document physical or mental disability	106.18
D9440	Office visit – after regularly scheduled hours	21-99		Yes	No		narrative of medical necessity	81.01
D9944	Occlusal guard – hard appliance, full arch	21-99	oral cavity designator 01 and 02.	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	285.08
D9945	Occlusal guard – soft appliance, full arch	21-99	oral cavity designator 01 and 02.	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	285.08

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D9946	Occlusal guard – hard appliance, partial arch	21-99	oral cavity designator 01 and 02.	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	285.08
D9951	Occlusal adjustment – limited	21-99		Yes	No		narrative of medical necessity	87.24
D9997	Dental case management – patients with special health care needs	21-99				A maximum of four dental case management services, per beneficiary, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider.		29.00
D9999	Unspecified adjunctive procedure, by report	21-99		Yes	No		narrative of medical necessity	By Report