JPSD86 PPO Illinois Consumer Coverage Disclosure (ICCDA)

Since 2023 and in accordance with the Illinois Consumer Disclosure Act, we are required to notify enrolled employees of the difference between our health plan benefits and the Minimum Essential Health Benefits available through the Marketplace (healthcare.gov).

For Reference:

https://labor.illinois.gov/

What does the information in the "Benchmark Page # Reference" column in the Listing refer to?

The page numbers in that column refer to where the benefit in question appears in the Access to Care and Treatment Benchmark Plan and the Pediatric Dental Plan as provided by the Department of Insurance (both enclosed in this material).

Please visit our District website for the most up to date health benefit information.

All booklets, summaries & schedules can be found in the Documents section.

Employer Name:	Joliet Public Schools District 86
Employer State of Situs:	Illinois
Name of Issuer:	BCBS
Plan Marketing Name:	JPSD86 PPO Plan
Plan Year:	2024

In accordance with the Illinois Consumer Coverage Disclosure Act, the Illinois legislature is requesting that employers provide a comparison of employer provided benefits as compared to Affordable Care Act marketplace plans ("Marketplace plans") such that interested individuals may compare an employer plan to the Marketplace.

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Covered
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Not Covered
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Covered
4	Durable Medical Equipment	Ambulatory	Pg. 13	Covered
5	Hospice	Ambulatory	Pg. 28	Covered
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Covered
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Covered
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Covered
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Covered
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Covered
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Covered
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Covered
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Covered
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Covered
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Covered
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Covered
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Covered
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Covered
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Covered
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Covered
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Covered

22	**Intranasal opioid reversal agent associated with opioid prescriptions**	**MH/SUD**	**Pg. 32**	Not Covered
23	**Mental (Behavioral) Health Treatment (Including Inpatient Treatment)**	**MH/SUD**	**Pgs. 8 -9, 21**	Covered
24	**Opioid Medically Assisted Treatment (MAT)**	**MH/SUD**	**Pg. 21**	Covered
25	**Substance Use Disorders (Including Inpatient Treatment)**	**MH/SUD**	**Pgs. 9 & 21**	Covered
26	**Tele-Psychiatry**	**MH/SUD**	**Pg. 11**	Covered
27	**Topical Anti-Inflammatory acute and chronic pain medication**	**MH/SUD**	**Pg. 32**	Covered
28	**Pediatric Dental Care**	**Pediatric Oral and Vision Care**	**See AllKids Pediatric Dental Document**	Not Covered
29	**Pediatric Vision Coverage**	**Pediatric Oral and Vision Care**	**Pgs. 26 - 27**	Not Covered
30	**Maternity Service**	**Pregnancy, Maternity, and Newborn Care**	**Pgs. 8 & 22**	Covered
31	**Outpatient Prescription Drugs**	**Prescription drugs**	**Pgs. 29 - 34**	Covered
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Covered
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Covered
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Covered
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Covered
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Covered
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Covered
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Covered
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Covered
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Covered
41	**Chiropractic & Osteopathic Manipulation**	**Rehabilitative and Habilitative Services and Devices**	**Pgs. 12 - 13**	Covered
42	**Habilitative and Rehabilitative Services**	**Rehabilitative and Habilitative Services and Devices**	**Pgs. 8, 9, 11, 12, 22, & 35**	Covered

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Brown & Brown, Inc. and its affiliated entities ("Brown & Brown") have made a good faith effort in preparing the Illinois Essential Health Benefit Listing form required under the Illinois Consumer Coverage Disclosure Act, at the request of your employer. The form was prepared on behalf of your employer based on information provided to us by the medical plan BlueCross BlueShield of Illinois& in conjunction with our understanding and interpretation of the Illinois Consumer Coverage Disclosure Act. Brown & Brown assumes no liability, whatsoever, in connection with the content of this form.

Your Health Care Benefit Program

The Access to Care and Treatment (ACT) Plan

The Access to Care and Treatment (ACT) Plan serves as a baseline for the minimum scope of benefits that most health plans sold in the individual and small group markets must cover at equal or greater value.
Since the inception of the ACA, federal guidance has allowed each state the opportunity to select from 10 base-benchmark plans:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plan options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment;
- The Health Maintenance Organization (HMO) plan with the largest insured commercial non-Medicaid enrollment in the state.

Absent a selection by the state, the largest small-group plan has served as the benchmark plan in the past.

For Plan Year 2020, the Centers for Medicare & Medicaid Services (CMS) is giving states greater flexibility in selecting a benchmark plan by providing three **new**, additional options. Illinois can:

- **OPTION 1:** Select an EHB-benchmark plan that another state used for the 2017 plan year;
- **OPTION 2:** Replace one or more categories of EHBs under it EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from another state's EHB-benchmark plan for 2017; OR
- **OPTION 3: Select a set of benefits that would become the benchmark plan for Illinois subject to federal guidelines.**

The Illinois Department of Insurance (IDOI) used this opportunity to explore how it could enhance the current benchmark plan benefits. The IDOI is utilizing Option 3 above and has selected the following set of benefits as the Illinois benchmark plan, subject to Federal guidelines.

Table of Contents

DEFINITIONS SECTION

Throughout this selection of benefits benchmark plan, many words are used which have a specific meaning when applied to health care coverage. These terms will always begin with a capital letter. When you come across these terms, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply.

ADVANCED PRACTICE NURSE.....means a Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

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ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA investigational new drug application.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Use Disorder.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(iv) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(v) is a graduate of an advanced practice nursing program.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse;

and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CIVIL UNION.....means a legal relationship between two persons, of either the same or opposite sex,

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this Certificate.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders, Congenital or Genetic Disorders may also include, but are not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma or injury.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under this Certificate begins.

COVERED SERVICE.....means a service or supply specified in this Certificate for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health benefit plan under section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another domestic partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorder as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMERGENCY SERVICES.....means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

HABILITATIVE SERVICES....means Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a treatment plan to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder, including but not limited to health care services that help a person keep, learn, or improve skills and functioning for daily living.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY..... Medically Necessary means that a specific medical, health care, supply or Hospital service is required, for the treatment or management of a medical symptom or condition and that the service, supply or care provided is the most efficient and economical service which can safely be provided.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

"Serious Mental Illness".....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;

(ii) Paranoid and other psychotic disorders;

(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);

(iv) Major depressive disorders (single episode or recurrent);

(v) Schizoaffective disorders (bipolar or depressive);

(vi) Pervasive developmental disorders;

(vii) Obsessive-compulsive disorders;

(viii) Depression in childhood and adolescence;

(ix) Panic disorder;

(x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(xi) Anorexia nervosa and bulimia nervosa.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function.

SUBSTANCE USE DISORDER.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc.

PHYSICIAN BENEFITS SECTION

This section of your Certificate tells you what services are covered. The benefits of this section are subject to all the terms and conditions of your Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of your Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.
For benefits to be available, under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.
Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Certificate had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.
2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective)

Additional Surgical Opinion
Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge after you have met your program deductible. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care
Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Substance Use Disorder Treatment Facility, or a Skilled Nursing Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or a Coordinated Home Care Program or
3. you visit your Physician's office or your Physician comes to your home or
4. you utilize telepsychiatry care (care may be provided by either a prescriber or licensed therapist).

Consultations
Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education
Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professional with expertise in diabetes management. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Radiation Therapy Treatments

Electroconvulsive Therapy

Speech Therapy
Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Breast Cancer Pain Medication and Therapy — Benefits will be provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this policy.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in your Certificate. Benefits for mammograms, other than routine, should be provided at the same payment level as Outpatient Diagnostic Service.

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration.

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Investigational Treatment—Benefits will be provided for routine patient care in conjunction with investigational treatments when medically appropriate and you have a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this Certificate if not provided in connection with an Approved Clinical Trial program.
Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment

of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 25 visits per benefit period.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

Routine Pediatric Hearing Examination—Benefits will be provided for routine hearing examinations.

Pulmonary Rehabilitation Therapy – Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Emergency Care

Benefits for Emergency Accident Care will be provided at the Emergency Accident Care payment level specified in the Benefit Highlights of your Certificate when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

Benefits for Emergency Medical Care will be provided at the Emergency Medical Care payment level specified in the Benefit Highlights of your Certificate when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. However, Covered Services for Emergency Medical Care for the examination and testing of a victim of a criminal sexual assault or abuse

to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, should be paid at 100% of the Maximum Allowance, if specified in your Certificate.

HOSPITAL BENEFIT SECTION

This section of your Certificate tells you what Hospital services are covered.

The benefits of this section are subject to all the terms and conditions of this Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, Board and General Nursing Care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary Services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Mammograms—Benefits for routine mammograms will be provided at the benefit payment level described in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate. Benefits for mammograms, other than routine, will be provided at the same payment level as Outpatient Diagnostic Service.

11. Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
12. Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
13. Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
14. Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.
15. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis. Unless otherwise stated, benefits will be provided at the benefit payment level described in the section entitled, "preventive care services" in the SPECIAL CONDITIONS AND PAYMENTS section of this Certificate.

OTHER COVERED SERVICES

This section describes "Other Covered Services" and the benefits that will be provided for them.

- S The processing, transporting, storing, handling and administration of blood and blood components.
- S Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- S Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- S Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- S Oxygen and its administration
- S Medical and surgical dressings, supplies, casts and splints
- S Naprapathic Service—Benefits will be provided for Naprapathic Services when rendered by a Naprapath. Benefits for Naprapathic Services will be limited to a maximum of 15 visits per benefit period.
- S Hearing Aids—Benefits will be provided bone anchored hearing aids.
- S Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

SPECIAL CONDITIONS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Certificate, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

Preventive Care Services

In addition to the benefits otherwise provided for in your Certificate, (and notwithstanding anything in your Certificate to the contrary), the following benefits for preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

___S evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

___S immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;

___S evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and

___S with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this preventive care services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

Preventive Care Services for Adults:

1. Abdominal aortic aneurysm screening for men who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over age 50
7. Depression screening
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - _ Hepatitis A
    - _ Hepatitis B
    - _ Herpes Zoster
    - _ Human papillomavirus
    - _ Influenza (Flu shot)
    - _ Measles, Mumps, Rubella
    - _ Meningococcal
    - _ Pneumococcal
    - _ Tetanus, Diphtheria, Pertussis
    - _ Varicella
12. Obesity screening and counseling
13. Sexually transmitted infections (STI) prevention
14. Tobacco use screening and cessation interventions for tobacco users
15. Syphilis screening for adults at higher risk

Preventive Care Services for Women (including pregnant women):

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract screening or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
6. Cervical cancer screening for sexually active women
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women

15. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
16. Osteoporosis screening for women over age 60, depending on risk factors
17. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
19. Sexually transmitted infections (STI) counseling for sexually active women
20. Syphilis screening for all pregnant women or other women at increased risk
21. Well woman visits to obtain recommended preventive services
22. Mammography for women at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

Preventive Care Services for Children:
1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Depression screening for adolescents
7. Development screening for children under age 3, and surveillance throughout childhood
8. Dyslipidemia screening for children at higher risk of lipid disorder
9. Fluoride chemoprevention supplements for children without fluoride in their water source
10. Gonorrhea preventive medication for the eyes of all newborns
11. Hearing screening for all newborns
12. Height, weight and body mass index measurements
13. Hematocrit or hemoglobin screening
14. Hemoglobinopathies or sickle cell screening for all newborns
15. HIV screening for adolescents at higher risk
16. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - _ Hepatitis A
    - _ Hepatitis B
    - _ Human papillomavirus
    - _ Influenza (Flu shot)
    - _ Measles, Mumps, Rubella
    - _ Meningococcal
    - _ Pneumococcal
    - _ Tetanus, Diphtheria, Pertussis
    - _ Varicella
    - _ Haemophilus influenzae type b
    - _ Rotavirus
    - _ Inactivated Poliovirus
    - _ any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
17. Iron supplements for children ages 6 to 12 months at risk for anemia
18. Lead screening for children at risk for exposure
19. Medical history for all children throughout development
20. Obesity screening and counseling
21. Oral health risk assessment for younger children up to ten years old

22. Phenylketonuria (PKU) screening for newborns
23. Sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis
25. Vision screening for all children
26. Autism screening provided without regard to the Covered Person's age

SKILLED NURSING FACILITY CARE
The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

AMBULATORY SURGICAL FACILITY
Benefits for all the Covered Services previously described in this Certificate are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT
Benefits for all the Covered Services described in your Certificate are available for Substance Use Disorder Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Rehabilitation Treatment in a Residential Treatment Center.

DETOXIFICATION
Covered Services received for detoxification are not subject to the Substance Use Disorder treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES
Benefits for all the Covered Services described in your Certificate are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder, including behavioral health treatment. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

OPIOID USE DISORDER
Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.

BARIATRIC SURGERY
Benefits for Covered Services received for Bariatric Surgery will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this Certificate, the same as for any other condition.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition and will be provided without regard to the Covered Person's age. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by (a) a Physician or a Psychologist who has determined that such care is medically necessary, or, (b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:

- S psychiatric care, including diagnostic services;
- S psychological assessments and treatments;
- S habilitative or rehabilitative treatments;
- S therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES

Your benefits for Habilitative Services for persons with a Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all the following conditions are met:

1. A Physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
2. Treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, Clinical Social Worker, or Psychologist upon the referral of a Physician; and
3. Treatment must be Medically Necessary and therapeutic and not Investigational.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges, b) one routine Inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery and c) one Inpatient hearing screening. If the newborn child needs treatment for an illness, injury, congenital defect, birth abnormality or a premature birth, benefits shall be effective from the date of the birth.

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection. Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.
Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless; and
- You have not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this Certificate in your lifetime is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

SPECIAL LIMITATIONS

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.
4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all the Covered Services previously described in your Certificate are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at least every year for women ages 40 and over or at the age and intervals considered medically necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening of an entire breast or breasts, when determined to be medically necessary by your Physician.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific

evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and

4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under your Certificate is terminated, benefits will be provided for, and limited to, the Covered Services of this Certificate which are rendered by and regularly charged by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

PEDIATRIC VISION COVERAGE

Coverage for *Pediatric Vision Care* is made part of, and is in addition to any information you may have in your Certificate. Coverage for *Pediatric Vision Care* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical Certificate are not covered under this *Pediatric Vision Care benefit*.) All provisions in the medical Certificate apply to coverage for *Pediatric Vision Care* unless specifically indicated otherwise below.**

Definitions

Benefit Period – For purposes of *Pediatric Vision Care,* a period of time that begins on the later of:

1) the member's effective date of coverage, or
2) the last date a vision examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each covered member of a group or family.)

Pediatric Frame Collection – A collection of frames that are covered under the Pediatric Vision Care benefit which includes adult sizes for members up to age 19.

Provider – For purposes of *Pediatric Vision Care,* a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under a medical/surgical plan, through age 19, are eligible for coverage for *Pediatric Vision Care.* NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease for *Pediatric Vision Care.* Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available for *Pediatric Vision Care.*

Limitations and Exclusions

In addition to the general limitations and exclusions listed in your medical/surgical certificate, *Pediatric Vision Care* does not cover services or materials connected with or charges arising from:

Any vision service, treatment or materials not specifically listed as a covered service;

Services and materials that are experimental or investigational;

Services or materials which are rendered prior to your effective date;

Services and materials incurred after the termination date of your coverage unless otherwise indicated;

Services and materials not meeting accepted standards of optometric practice;

Services and materials resulting from your failure to comply with professionally prescribed treatment;

Telephone consultations;

Any charges for failure to keep a scheduled appointment;

Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

Services or materials provided as a result of intentionally self-inflicted injury or illness;

Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;

Office infection control charges;

Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;

State or territorial taxes on vision services performed;

Medical treatment of eye disease or injury;

Visual therapy;

Special lens designs or coatings other than those described in this brochure;

Replacement of lost/stolen eyewear;

Non-prescription (Plano) lenses;

Two pairs of eyeglasses in lieu of bifocals;

Services not performed by licensed personnel;

Prosthetic devices and services (*prosthetic devices and services are covered as a medical benefit and may be found in the PHYSICIAN BENEFIT SECTION of this Certificate)*;

Insurance of contact lenses;

Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.
Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.
The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Certificate.

Benefit Payment for Hospice Care Program Services
Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM
BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This Benefit Section of your Certificate explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

The benefits of this section are subject to all the terms and conditions of your Certificate. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

NOTE: The use of an adjective such as Participating or Specialty in modifying a Pharmacy shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Pharmacy. In addition, the omission, non-use or non-designation of Participating or any similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Pharmacy.

For purposes of this Benefit Section only, the following definitions shall apply:

AVERAGE WHOLESALE PRICE.....means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BRAND NAME DRUG.....means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Formulary or Non-Formulary Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Formulary or Non-Formulary Brand Name.

COINSURANCE AMOUNT.....means the percentage amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COMPOUND DRUGS.....means those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

COPAYMENT AMOUNT.....means the dollar amount paid by you for each Prescription Order filled or refilled through a Participating Pharmacy or Non-Participating Pharmacy.

COVERED DRUGS.....means any Legend Drug (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration):

(i) Which is Medically Necessary and is ordered by a Health Care Practitioner naming you as the recipient;

(ii) For which a written or verbal Prescription Order is provided by a Health Care Practitioner;

(iii) For which a separate charge is customarily made;

(iv) Which is not entirely consumed or administered at the time and place that the Prescription Order is written;

(v) For which the FDA has given approval for at least one indication; and

(vi) Which is dispensed by a Pharmacy and is received by you while covered under this Benefit Section, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to the EXCLUSIONS provision later in this Benefit Section).

FORMULARY BRAND NAME DRUG.....means a brand name prescription drug product that is identified on the *Formulary Drug List* and is subject to the Formulary Brand Name Drug payment level.

GENERIC DRUG.....means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired.

LEGEND DRUGS.....means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

MAINTENANCE DRUGS.....means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

NATIONAL DRUG CODE (NDC).....means a national classification system for the identification of drugs.

NON-FORMULARY BRAND NAME DRUG.....means a Brand Name Drug which does not appear on the *Formulary Drug List* and is subject to the Non-Formulary Brand Name Drug payment level.

PHARMACY.....means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

PRESCRIPTION ORDER.....means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Benefit Section.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy.

ABOUT YOUR BENEFITS

Formulary Drug List

Formulary drugs are regulated by the FDA, selected and displayed per your certificate. Some of the factors evaluated when certificate's select the formulary drugs include each drug's safety, effectiveness, cost and how it compares with drugs currently on the formulary.

Most certificates consider drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time.

The Formulary Drug List included is an example list of drugs in each category and class. Issuer plans are required to include at least the same number of drugs in each category and class as represented in the Formulary Drug List.

Prior Authorization/Step Therapy Requirement
When certain medications and drug classes, such as medications used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, and more serious forms of anemia, hypertension, epilepsy, and psoriasis are prescribed, your Physician may be required to obtain authorization for your medication to be eligible for benefits under your Certificate. Medications included in this program are subject to change and other medications for other conditions may be added to the program. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the brand name medication.

Dispensing Limits
If a Prescription Order that is not an opioid prescription, is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Short-term opioid prescriptions for acute pain will be provided for no more than 7 days. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

COVERED SERVICES

Benefits for Medically Necessary Covered Drugs prescribed to treat you for a chronic, disabling, or life-threatening illness are available if the drug:

1. Has been approved by the FDA for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed:
    a. a prescription drug reference compendium approved by the Department of Insurance, or
    b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded in this Benefit Section, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names.

Injectable Drugs
Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Immunosuppressant Drugs
Benefits are available for Medically Necessary immunosuppressant drugs with a written prescription after an approved Human Organ Transplant.

Fertility Drugs
Benefits are available for Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of infertility with a written prescription.

Diabetic Supplies for Treatment of Diabetes
Benefits are available for Medically Necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- x Test strips specified for use with a corresponding blood glucose
  monitor S Glucose test solutions
- S Glucagon
- S Glucose tablets
- x Lancets and lancet devices
- x Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- x Insulin and insulin analog preparations

- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

Vaccinations
Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayment or dollar maximum when such services are received in compliance with your certificate.

Self-Administered Cancer Medications
Benefits will be provided for self-administered cancer medications, including pain medication.

Breast Cancer Pain Medication and Therapy — Benefits will be provided for all Medically Necessary pain medication related to the treatment of breast cancer. Benefits will also be provided for all Medically Necessary pain therapy related to the treatment of breast cancer under the PHYSICIAN BENEFIT SECTION of this policy.

Cancer Medications
Benefits will be provided for orally administered cancer medications, intravenously administered cancer medications or injected cancer medications that are used to kill or slow the growth of cancerous cells. Your Copayment Amount or Coinsurance Amount or deductible will not apply to orally administered cancer medications.

Opioids
Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.

Acute and Chronic Pain
Benefits will be provided for topical anti-inflammatory medication including, but not limited to, Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

PRESCRIPTION DRUG EXCLUSIONS

For purposes of this Benefit Section only, the following exclusions shall apply:

1. Drugs which do not by law require a Prescription Order from a Provider or Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels,); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, male contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's or Health Care Practitioner's office or during confinement while as a patient in a Hospital, or other acute care institution or facility, including take-home drugs or samples; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
8. Drugs which are repackaged by a company other than the original manufacturer.
9. Drugs dispensed in quantities in excess of the day supply amounts stipulated in this Benefit Section, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
10. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except for the treatment of certain types of cancer when a particular legend drug has been shown to be effective for the treatment of that specific type of cancer even though that legend drug has not been approved for that type of cancer. The drug must have been shown to be effective for the treatment of that particular cancer according to the Federal Secretary of Health and Human Services.
11. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
12. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
13. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, or not Medically Necessary.
14. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
15. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your employer's group health care plan, or for which benefits have been exhausted.

16. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
17. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
18. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength.
19. Athletic performance enhancement drugs.
20. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form, except when used to treat Medically Necessary Covered Services resulting from an organic disease or illness, injury or congenital defect.
21. Some equivalent drugs manufactured under multiple brand names. XXXXXXXXXX may limit benefits to only one of the brand equivalents available. Compound Drugs
22. Medications in depot or long acting formulations that are intended for use longer than the covered days' supply amount.

ALL OTHER EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, or health care services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not Medically Necessary as defined by this Certificate.

— Services or supplies that are not specifically mentioned in this Certificate.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this Certificate for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under your Certificate if not provided in connection with a qualified clinical cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

— Special braces, specialized equipment, appliances, ambulatory apparatus, except as specifically mentioned in this Certificate.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except for Pediatric Vision and as specifically mentioned in this Certificate.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Immunizations, unless otherwise specified in this Certificate.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services, except as they relate to Autism Spectrum Disorder(s).

— Hearing aids, except for hearing aids for children or bone anchored hearing aids (osseointegrated auditory implants), examinations for the prescription or fitting of hearing aids, unless otherwise specified in this Certificate.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are employees of the Group and each is covered separately under this Certificate.

— Diagnostic Service as part of premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.

— Residential Treatment Centers, except for Inpatient Substance Use Disorder Rehabilitation Treatment or Inpatient Mental Illness and as specifically mentioned under this Certificate

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this Certificate.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.

— Abortions, including related services and supplies, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or

incest.

- Repair and replacement for appliances and/or devices due to misuse or loss, except as specifically mentioned in this Certificate.

- Acupuncture, whether for medical or anesthesia purposes.

*****Stand-alone pediatric dental remains identical to prior years' submissions, titled "DentaQuest of Illinois, LLC" (aka AllKids Pediatric Dental)*****

DentaQuest of Illinois, LLC

Effective September 1, 2011

Dental Office Reference Manual

12121 N. Corporate Parkway
Mequon, WI 53092
1.888.281.2076
Fax 262.241.7401
www.dentaquest.com

DentaQuest of Illinois, LLC
Address and Telephone Numbers

DentaQuest of Illinois, LLC

Customer Service
(For HFS Beneficiaries)
12121 North Corporate Parkway
Mequon, WI 53092
1.888.286.2447
Fax: 1.262.834.3450
TTY (Hearing Impaired) 1.800.466.7566

Information Systems
12121 North Corporate Parkway
Mequon, WI 53092
1.888.875.7482

Prior Authorization/Retrospective Review
12121 North Corporate Parkway
Mequon, WI 53092
1.888.875.7482
Fax: 1.262.241.7150

Prior Authorizations and Retrospective Reviews should be sent to:
DentaQuest of Illinois, LLC
Prior Authorizations
12121 North Corporate Parkway
Mequon, WI 53092

Dental claims should be sent to:
DentaQuest of Illinois, LLC
Claims
12121 North Corporate Parkway
Mequon, WI 53092

Dental claims for services performed in a HOSPITAL should be sent to:
DentaQuest of Illinois, LLC
Attn. Hospital Claims
P.O. Box 339
Mequon, WI 53092

Electronic files or diskettes should be sent to:
DentaQuest of Illinois, LLC
Information Systems
12121 North Corporate Parkway
Mequon, WI 53092

Provider Relations (Claims Questions)
12121 North Corporate Parkway
Mequon, WI 53092
1.888.281.2076
Fax: 1.262.241.7379
Email: denclaims@dentaquest.com

IL Department of Healthcare and Family Services (HFS)

Dental Program Manager
607 East Adams
Springfield, IL 62701
1.217.557.5438

HFS Provider Hotline
1.800.842.1461

HFS Beneficiary Hotline
1.800.226.0768

TTY (Hearing Impaired) Hotline
1.877.204.1012

Department of Specialized Care for Children
2815 West Washington
Suite 300, Box 19481
Springfield, IL 62794-9481
1.800.322.3722

Fair Hearings (Appeals)
HFS
Bureau of Administrative Hearings
401 South Clinton Street, 6th floor
Chicago, IL 60607
1.800.435.0774

Fraud Hotline
1.800.252.8903

TTY (Hearing Impaired) Fraud Hotline
1.800.447.6404

HFS Primary Care Case Management
Phone: 1.877.912.1999
Web site: www.illinoishealthconnect.com

DentaQuest of Illinois, LLC

Statement of Beneficiary Rights and Responsibilities

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

1. All Beneficiaries have a right to receive pertinent written and up-to-date information about DentaQuest, the services DentaQuest provides, the participating dentists and dental offices, as well as Beneficiary rights and responsibilities.

2. All Beneficiaries have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care, which is a private and personal service.

3. All Beneficiaries have the right to fully participate with caregivers in the decision making process surrounding their health care.

4. All Beneficiaries have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

5. All Beneficiaries have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Beneficiary's expectations.

6. All Beneficiaries have the right to appeal any decisions related to patient care and treatment.

7. All Beneficiaries have the right to make recommendations regarding DentaQuest's/Healthcare and Family Services' Beneficiary rights and responsibilities policies.

Likewise:

1. All Beneficiaries 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 healthcare services.

2. All Beneficiaries have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

3. All Beneficiaries have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

DentaQuest of Illinois, LLC

Statement of Provider Rights and Responsibilities

Enrolled Participating Providers shall have the right to:

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

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

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

4. Supply accurate, relevant, factual information to a Beneficiary in connection with a complaint filed by the Beneficiary.

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

Likewise:

1. If a recommended course of treatment is not covered, e.g., not approved by HFS/DentaQuest, the participating dentist, if intending to charge the Beneficiary for the non-covered services, must notify the Beneficiary. See Section 2.01 of the DORM.

2. A provider intending to terminate participation in the HFS dental program due to retirement, relocation or voluntary termination is requested to provide DentaQuest with written notification of termination at least 90 days prior to expected final date of participation. A list of existing Illinois HFS Dental Program patients currently in treatment and the treatment status should accompany the notification. All other HFS patients should be referred to the DentaQuest's toll-free referral number (1.888.286.2447) to find another dentist in the area taking referrals when services are needed.

3. A provider may not bill both medical and dental codes for the same procedure.

4. A provider must notify DentaQuest of changes to address, phone, fax, tax ID, or other relevant information.

* * *

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

Dental Office Reference Manual
Table of Contents

1.00 Beneficiary Eligibility Verification Procedures and Services to Beneficiaries

1.01 Beneficiary Eligibility Card

HFS Beneficiaries are issued eligibility cards monthly.

Providers are responsible for verifying that Beneficiaries are eligible at the time services are rendered and to determine if Beneficiaries have other health insurance.

DentaQuest recommends that each dental office make a photocopy of the Beneficiary's eligibility card each time treatment is provided. An eligibility card guarantees that a Beneficiary is currently enrolled in the HFS Medical Benefits Program for the dates identified on the card.

In addition, DentaQuest recommends that each dental office make a photocopy of the Beneficiary's photo identification card (driver's license or state identification card) and maintain the copy in the dental health record. If the Beneficiary is a minor and does not have a photo identification card, DentaQuest recommends that the office make a photocopy of the parent's or guardian's photo identification card to maintain in the Beneficiary's dental record.

The Beneficiary's (or the parent's or guardian's) identification should be verified by photo identification at each visit to prevent fraudulent use of the Beneficiary's MediPlan card.

If medical coverage is restricted in any way, a printed message will appear on the front of the card. Individuals receiving the cards listed below are not eligible for HFS Dental Program benefits. Examples of these printed restriction messages include:

QMB Only: Beneficiary is eligible for medical benefits only. The Beneficiary is not covered for dental benefits.

Illinois Healthy Women: (The Illinois Healthy Women card is pink.)
Coverage limited to family planning exams, birth control, pap smears, mammograms, labs, and diagnostic tests related to family planning and treatment of STD's found at a family planning visit. There are no copays for family planning services. Certain other prescription drugs may be subject to copays.

Non-citizen Renal: Only End Stage Renal Disease services are covered. Organ transplants and other related services are not covered.

Spenddown Beneficiaries receive eligibility cards only for periods when their spenddown has been met and they are actually eligible for payment for their medical (and dental) expenses.

See **Attachment B** for a copy of the card and an explanation of the information contained on the card. For additional information concerning Beneficiary Eligibility Cards, please contact DentaQuest's Provider Relations Department at 1.888.281.2076

1.02 Handbook for Providers of Medical Services

The Department's *Handbook for Providers of Medical Services* is available for your review on the HFS Medical Provider Handbooks Web site. Please refer to Chapter 100 (General Policy and Procedures), for information necessary for providers to receive payment from the Department. If you do not have access to the Internet, please call 1.217.782.0538 or 1.217.524.7306 to request a copy of the handbook.

1.03 DentaQuest Eligibility Systems

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at 1.888.875.7482 and press 1 for eligibility. The IVR system is able to answer all of your eligibility questions for as many Beneficiaries 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. Beneficiary history. Using your telephone keypad, you can request eligibility information on a HFS Beneficiary by entering your 6 digit DentaQuest location number, the Beneficiary's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below.

Directions for using DentaQuest's IVR to verify eligibility:

1. Call DentaQuest Customer Service at 1.888.875.7482.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the Beneficiary's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the Beneficiary ID.
7. Does the Beneficiary's ID have only numbers in it? If so, press or say 2. When prompted, enter the Beneficiary ID.
8. Upon system verification of the Beneficiary's eligibility, you will be prompted to repeat the information given, verify the eligibility of another Beneficiary, get benefit information, get limited claim history on this Beneficiary, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Beneficiary (s), you will be asked to repeat steps 5 through 8 above for each Beneficiary.

If the system is unable to verify the Beneficiary information you entered, you will be transferred to a Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Web site currently allows Enrolled Participating Providers to verify a Beneficiary's eligibility as well as submit claims directly to DentaQuest. You can verify the Beneficiary's eligibility on-line by entering the Beneficiary's date of birth, the expected date of service and the Beneficiary's identification number or last name and first initial.

To access the eligibility information via DentaQuest's Web site, simply log on to the DentaQuest Web site. Once you have entered the Web site, click on the "Dentist" icon. From there choose "Illinois" and press "go". You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. You should have received information from DentaQuest on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 1.888.875.7482. Once logged in, select "Patient" and then "Member Eligibility Search" and then enter the applicable information for each member you are checking. You are able to check on an unlimited number of patients and can print a summary of eligibility for your records.
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 Web sites, please contact the Customer Service Department at 1.888.281.2076 – select option "3". They will be able to assist you in utilizing either system.

1.04 All Kids/HFS Dental Program Copayments

All Kids Program eligibility cards authorizing services are issued in the same manner as the MediPlan Card, except that the All Kids Program card is canary yellow in color. The card indicates the Beneficiary is covered by "All Kids" and is issued on a monthly basis.

Some All Kids Program Beneficiaries have copayment responsibilities. Copayment amounts are noted on the eligibility card. The copayment amount is in addition to state reimbursement for the procedure and is collected at the dentist's discretion. If the family has reached the maximum, it will be printed on the eligibility card (or the Beneficiary may have a written notice stating this) and no copayment should be collected. Please see **Attachment CC** for a full list of Beneficiary Copayments.

Please Note: No copayments may be charged for routine preventive and diagnostic dental services rendered to children including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

The contracted fees paid to individual providers by DentaQuest for services to Beneficiaries at all levels of the All Kids/HFS Dental Program are the same, regardless of any copayments collected by the provider. Providers keep any copayments they collect. Claims for these services are to be submitted to DentaQuest of Illinois, LLC.

1.05 Expanded Dental Services for Certain Beneficiaries

In addition to the normal HFS Dental Program services, certain Beneficiaries qualify for dental services not covered through the HFS Dental Program. These dental services are covered as part of a Supportive Services program managed through the Department of Human Services (DHS) to treat conditions that are a barrier to employment.

The DHS caseworker may contact DentaQuest or refer the Beneficiary to a dentist enrolled in the Dental Program to determine whether the necessary dental services are covered under the HFS Dental Program.

To be eligible for these services the Beneficiary must obtain a written description of the required dental services and the cost estimates. The dentist's statement must also include the dentist's name, address, phone number, dental license number, Social Security Number or FEIN, fees and dentist's signature.

The DHS Local Office Administrator makes the decision to approve or deny the dental services. The Beneficiary and the dentist are notified of the decision (Form 1934).
Once the dental work has been completed, the dentist bills the local DHS office at the address listed on the approval memo and includes the approval forms with the dentist's statement.

The dentist will receive payment at the maximum allowable HFS Dental Program rate or the actual charge, whichever is less. Payments are usually made within 30 days of the receipt of the claim at the Springfield Central Office. Information on the status of the payment should be directed to the DHS caseworker.

1.06 Transportation Benefits for Certain Beneficiaries

Beneficiaries who need assistance with transportation should contact DentaQuest's Customer Service Department directly at 1.888.286.2447.

The State of Illinois contracts with a transportation vendor to handle all transportation requests. DentaQuest provides the transportation vendor's toll-free phone number to Beneficiaries who inquire about transportation and are eligible for the State's transportation benefits.

Transportation benefits are available for most Beneficiaries. For those who are eligible, once a request is made, the Beneficiaries must allow 7 days before scheduling transportation, as the State requires this time to review and approve the request.

Please note: If a Beneficiary is seeing a specialist and he/she needs transportation, the Beneficiary must have a written referral from a general dentist. There are **no specific forms**. The general dentist may simply provide a notation of treatment required on office letterhead. This written referral is required by HFS' transportation vendor and HFS in order for the Beneficiary to receive transportation to go to the specialist.

1.07 Consent Process for DCFS Wards

There are two types of consent for DCFS wards related to dental care – one for ordinary and routine medical and dental care and one for medical/surgical treatment. Caregivers for DCFS wards do not have the authority to provide consent; such consent must be provided by the DCFS Guardianship Administrator or an authorized agent.

As a general rule, DCFS and private agency caseworkers are responsible for obtaining consents for children in their caseload. If you have not received a signed consent for providing care to a DCFS ward, please speak with the child's caseworker (or ask the foster parent to speak with the caseworker) to attain a signed consent form appropriate for the type of care being rendered. To receive a consent form for rendering medical/surgical treatment, be prepared to give detailed information regarding the procedure, including its risks and benefits.

If a DCFS ward arrives for dental care on a weekday (between 8:30 AM and 5:00 PM) and you do not have a consent form, please contact the DCFS Consent Unit at 1.800.828.2179 for assistance. The DCFS Consent Unit can facilitate your obtaining a consent form so that the appointment does not need to be rescheduled. If urgent treatment is required during weekends, holidays and after regular office hours, please call DCFS at 1.773.538.8800 or 1.217.782.6533 to obtain a consent form.

1.08 HFS Dental Program Brochures

Annually, DentaQuest mails an informational brochure to the household of every enrolled Beneficiary in Illinois. This brochure provides an overview of the dental benefits available to HFS Dental Program Beneficiaries in Illinois and gives instructions on how to receive a referral for a dental provider. Copies of these brochures are available for providers to print (in English, Spanish, Chinese, Polish, Russian, and French) on DentaQuest's Web site.

DentaQuest provides outreach to families of children who have not received a dental service within the last 12 months of enrollment. Dentists needing assistance in Beneficiary follow-up may contact DentaQuest at 1.888.281.2076 - select option "3".

1.09 DentaQuest Customer Service Numbers

DentaQuest offers Customer Service for Providers at 1.**888.281.2076**.

DentaQuest offers Customer Service for Beneficiaries at **1.888.286.2447**.

DentaQuest offers TTY service for hearing impaired Beneficiaries at **1.800.466.7566**.

1.10 Dental Periodicity Schedule

The Dental Periodicity Schedule is included as a recommendation of the ages at which certain oral health services should be provided for children. See Attachment DD for the complete Illinois Dental Periodicity Schedule.

2.00 Covered Benefits

Please refer to the following attachments for a complete list of covered benefits:

Coverage	Exhibit
Children	**A**
Adult	**B**

This section identifies program benefits and clearly defines individual age and benefit limitations, exclusions and special documentation requirements.

HFS Beneficiaries should receive the same access to dental treatment as any other patient in the dental practice. **Enrolled Participating Providers are not allowed to charge Beneficiaries for missed appointments.** Pursuant to Section 140.12(i) of the Illinois Administrative Code, payment made must be accepted as payment in full for covered services. Private reimbursement arrangements may be made only for Non-Covered Services, with the prior knowledge and consent of the HFS-enrolled Beneficiary.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 10 years, and records pertaining to the most recent 12 months must be available on-site.

All dental services performed must be recorded and signed by the rendering provider in the patient record. All records must be available as required by your Participating Provider Agreement.

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

DentaQuest recommends that Providers submit claims with their "Usual and Customary" charges. DentaQuest reimburses Providers for covered services at their billed charges or the approved HFS fee, whichever is less.

The DentaQuest claim system only recognizes the current American Dental Association CDT code list for services submitted for payment. Any procedure codes other than CDT codes will be rejected when submitted for payment. A complete copy of the current CDT book can be purchased from the American Dental Association at the following address and phone number:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1.800.947.4746

The guidelines in the benefit tables are all-inclusive for covered services and conform to generally accepted standards of dental practice.

Each category of service is contained in a separate table and lists:

- The approved procedure code to submit when billing,

- A brief description of the covered service,
- The age limits imposed on coverage,
- A description of documentation, in addition to a completed claim form, that must be submitted when a claim or request for prior authorization is submitted,
- An indicator of whether or not the service is subject to prior authorization, and
- Any other applicable benefit limitations.

2.01 Missed Appointments

DentaQuest offers the following suggestions to decrease the number of missed appointments.

- Contact the Beneficiary 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 another state agency such as DCFS, DSCC or DHS, contact staff from that program to ensure the scheduled appointment is kept.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a provider from billing a HFS Dental Program Beneficiary for a missed appointment. In addition, your missed appointment policy for HFS-enrolled patients cannot be stricter than that of your private or commercial patients.

If an HFS Beneficiary exceeds your office policy for missed appointments, you may choose to terminate the Beneficiary from your practice. Notify the Beneficiary of your decision and encourage him/her to contact DentaQuest at 1.888.286.2447 for a referral to a new dentist.

Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:

1.888.201.2076

2.02 Payment for Non-Covered Services

Enrolled Participating Providers shall hold Beneficiaries, DentaQuest, and HFS harmless for the payment of Non-Covered Services except as provided in this paragraph. A Provider may bill a Beneficiary for Non-Covered Services if the Provider obtains an agreement (in writing) from the Beneficiary prior to rendering such service that indicates:

- The services to be provided;
- DentaQuest and HFS will not pay for or be liable for said services; and
- Beneficiary will be financially liable for such services.

DentaQuest encourages Enrolled Participating Providers to obtain this agreement in writing, and on the date the service(s) is/are rendered, when possible. A sample "Agreement to Pay for Non-Covered Services Form" is included as **Attachment R**.

2.03 Electronic Attachments

A. **DentaQuest Provider Web Portal** – DentaQuest accepts radiographs and other attachments electronically via the DentaQuest Provider Web Portal. This is a free service to providers and is accessible on the DentaQuest Provider Web site. The portal allows transmissions via secure internet lines for radiographs, periodontal charts, intraoral pictures, narratives, and EOB's.

B. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests and claims submissions. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Enrolled 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 EOBs.

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

For more information or to sign up for FastAttach go to the NEA Web site or call NEA at 1.800.782.5150.

C. **OrthoCAD™** DentaQuest accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. DentaQuest allows Enrolled 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 clearinghouses or practice management systems.

To ensure your orthodontic authorizations are processed efficiently and timely, all orthodontia prior authorization submissions through email with OrthoCAD™ require an OrthoCAD™ submission form. If a request is received without the OrthoCAD™ submission form it will be returned to your office. A copy of the OrthoCAD™ submission form is included as **Attachment I.** .

For more information or to sign up for **OrthoCAD™**, visit the OrthoCAD™ Web site or call **OrthoCAD™** at 1.800.577.8767.

3.00 Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

Prior Authorization is a utilization tool that requires Providers to submit documentation associated with certain dental services for a Beneficiary. Providers are not paid if this documentation is not submitted to DentaQuest.

DentaQuest uses specific dental treatment criteria based on industry standards, as well as an evaluation process to determine if requested services are required. The criteria are included in this manual (see Sections 13 and 14). Please review these criteria as well as the Benefits (Exhibit A and B) covered to understand the decision-making process used to determine payment for services rendered.

Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Beneficiary, the State of Illinois or any agents, and/or DentaQuest.

Prior authorizations will be honored for 120 days from the date they are issued. An approval does not guarantee payment. The Beneficiary must be eligible at the time the services are rendered. The Provider should verify eligibility at the time of service.

Requests for prior authorization should be sent with the appropriate documentation on a standard ADA approved claim form.

The tables of covered services, Exhibits A and B, contain a column marked "Prior Authorization Required." A "Yes" in this column indicates that the service requires prior authorization to be considered for reimbursement. The "Documentation Required" column lists the information required for submission with the Prior Authorization request.

Within fourteen (14) days of receipt of a prior authorization or a retrospective review request, that in the opinion of DentaQuest requires additional information, DentaQuest will notify the Provider submitting the request that additional information is necessary. This additional information\documentation must be received within 30 days or the authorization request is denied.

Requests for Prior Authorization are granted or denied based upon whether the item or service is medically necessary, whether a less expensive service would adequately meet the Beneficiary's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

DentaQuest of Illinois, LLC, must make a decision on a request for prior authorization within thirty (30) days from the date DentaQuest receives this request, provided all information is complete. If DentaQuest does not decide on this request and send the Provider written notice of its decision on the services requested on this statement within thirty (30) days, the request will automatically be approved. If DentaQuest denies the approval for some or all of the services requested, DentaQuest will send the Beneficiary a written notice of the reasons for the denial(s) and will tell the Beneficiary that he or she may appeal the decision.

Retrospective Review

Services that normally require a Prior Authorization, but are performed in an emergency situation, are subject to a Retrospective Review. **These claims should be submitted to the same address used for submitting services for Prior Authorization, along with any required documentation.** Any claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

After the DentaQuest Consultant reviews the documentation, an authorization number is provided to the submitting office for tracking purposes and to maintain in the Beneficiary's record. For emergency services submitted for retrospective review, the claim is forwarded for processing. **The office will receive a Prior Authorization Determination document, but no further submission is necessary for payment.**

4.00 Dental Services in a Hospital Setting

As of January 1, 2005, dentists no longer have to obtain prior approval for dental procedures performed in a hospital outpatient setting or an Ambulatory Surgical Treatment Center (ASTC). All dental procedures performed in these outpatient settings are subject to post payment review.

Patient Criteria

Specific criteria must be met in order to justify the medical necessity of performing a dental procedure in the outpatient setting. The criteria are:

- The patient requires general anesthesia or conscious sedation;
- The patient has a medical condition that places the patient at an increased surgical risk, such as, but not limited to: cardio-pulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or
- The patient cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

Dental Billing Procedures

- Claims must include documentation to support the medical necessity for performing the procedure in the outpatient setting including a narrative specifying the medical necessity, supporting X-rays and any other explanation necessary to make a determination.
- Dentists must record a narrative of the dental procedure performed and the corresponding CDT dental codes in the patient's medical record at the outpatient setting. If the specific dental code is unknown, the code D9999 may be used.
- Claims must be submitted to DentaQuest for the covered professional services in the same format and manner as all standard dental procedures.
- Claims for services performed in a hospital must be sent to:

DentaQuest of IL, LLC.
Attn. Hospital Claims
PO Box 339
Mequon, WI 53092

Hospital/ASTC Billing Procedures

The hospital or ASTC will bill HFS for the all-inclusive rate for facility services using the assigned CDT/HCPCS dental code. The hospital must have this code in order to be paid for the facility services. The applicable dental codes will result in payment to hospital/ASTC for the Ambulatory Procedures Listing (APL) Group 1d – Surgical Procedures/Very Low Intensity. All facility bills for services performed in the outpatient setting should be forwarded to:

Department of Healthcare and Family Services
P.O. Box 19132
Springfield, Illinois 62794-9132

Participating Hospitals/ASTCs

Dentists must administer the services at a hospital or ASTC that is enrolled in the Illinois HFS Medical Benefits Program. Questions regarding hospital participation should be directed to the Bureau of Comprehensive Health Services toll-free at 1.877.782.5565.

5.00 Claim Submission Procedures

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

- Electronic claims via DentaQuest's Web site
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

5.01 Electronic Claim Submission Utilizing DentaQuest's Internet Web site

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

To submit claims via the Web site, simply log on to the DentaQuest Web site. Once you have entered the Web site, click on the "Dentist" icon. From there choose "Illinois" and press "go." You will then be able to log in using your password and ID. First time users need to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 1.888.281.2076 – select option "3". Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Web 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 Web site, please email our Systems Operations Department or by calling 1.888.560.8135.

5.02 Electronic Authorization Submission Utilizing DentaQuest's Internet Website

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

To submit pre-authorizations via the Web site, simply log on to the DentaQuest Web site. Once you have entered the Web site, click on the "Dentist" icon. From there choose "Illinois" and press "go." You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 1.888.281.2076 – select option "3". Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

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

5.03 Electronic Claim Submission via Clearinghouse

Dentists may submit their claims to DentaQuest via an electronic claims clearinghouse. Contact your software vendor and to ensure DentaQuest is listed as a payer. Your software vendor will provide you with the information you need to ensure that submitted claims are forwarded to DentaQuest.

5.04 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will, on a case by case basis, work with the Provider to receive their claims electronically via a HIPAA Compliant 837D file from the Provider's practice management system. Please e-mail Systems Operations Department or call 1.888.560.8135 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 NPPES Web site and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide (Attachment J) located on the Provider Web Portal.

5.06 Paper Claim Submission

Paper claims must be submitted on a 2006 or later ADA approved claim form. Please see **Attachment D** for a sample claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1.800.947.4746

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

The Provider and office location information must be clearly identified on the claim. To ensure proper claim processing, the claim form must include the following:

- The treating Provider's name;
- The treatment location;
- The billing (business office) location;
- The treating Provider's DentaQuest Provider ID or Illinois License Number;
- All pertinent National Provider Identification (NPI) numbers; and
- The Provider's signature (or signature must be on file at DentaQuest).

DentaQuest required NPI numbers on all incoming claims beginning May 23, 2008. DentaQuest requires providers to use the 2006 or later ADA claim form. On the 2006 ADA claim form, fields 49 and 54 have been allocated for NPI. Field 54 is to be populated

with the individual or Type I NPI number and field 49 should be populated with the group or Type II NPI number.

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

The DentaQuest claim system only recognizes the current American Dental Association CDT code list for services submitted for payment. Any procedure codes other than CDT codes will be rejected when submitted for payment.

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

Mail claims with proper postage. DentaQuest does not accept "postage due" mail. "Postage due" mail will be returned to the sender and will result in delay of payment.

Mail paper claims to the following address:

DentaQuest of IL, LLC
Claims
12121 N. Corporate Parkway
Mequon, WI 53092

5.07 Claims Adjudication and Payment

DentaQuest adjudicates claims on a weekly basis.

The average turnaround time between receipt of a clean claim and adjudication is seven days. During this seven day period, DentaQuest imports the data, edits the data for completeness and correctness, analyzes the data for clinical and coding correctness/appropriateness, and audits against product and benefit limits. Once these edits are complete, a remittance summary and check is printed. This occurs weekly.

Payments are released on a weekly basis, but this is dependent upon funding from the State of Illinois.

5.08 Direct Deposit

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

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

- Complete and sign the Direct Deposit Authorization Form (**Attachment E**)
- 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 – 1.262.241.4077
    - Via Mail – DentaQuest of Illinois, LLC

12121 North Corporate Parkway
Mequon, WI 53092
ATTN: PDA Department

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented

after the receipt of completed paperwork. Providers will receive a check 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 **(Attachment E)**. 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 Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the Dentist Web Portal at the DentaQuest Provider Web site or at DentaQuest's Enhanced Web Portal.
2. Under the Claims/Pre-Authorizations header, Select **Explanation of Benefits**
3. The **Explanation of Benefits** page will appear and will automatically populate your remittance advices.
4. To view the Explanation of Benefits detail, click on *Check or EFT Trace Number* to view that particular EOB in the pop-up window.
5. Click on any column header to sort the results.
6. Click Download File to download a copy of the results page.

5.09 Coordination of Benefits (COB)

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

5.10 Filing Limits

The timely filing requirement for the HFS Dental Program is 365 calendar days from the date of service. DentaQuest determines whether a claim has been filed timely by comparing the date of service to the date DentaQuest received the claim. If the span between these two dates exceeds 365 days, the claim is denied due to untimely filing.

5.11 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, DentaQuest performs an edit of all claims upon receipt. This edit validates Beneficiary eligibility, procedure codes and provider identifying information. DentaQuest 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 feel free to contact DentaQuest's Provider Relations Department at 1.888.281.2076 – select option "3" with any questions you may have regarding claim submission of your remittance.

Each Enrolled Participating Provider office receives an "explanation of benefit" report with it's remittance. This report includes Beneficiary information and an allowable fee by date of service for each service rendered during the period.

If a dentist wishes to appeal any reimbursement decision, he/she must submit the appeal in writing, along with any necessary additional documentation within 365 days to:

DentaQuest of Illinois, LLC
Appeals
12121 North Corporate Parkway
Mequon, WI 53092

Provider appeals should be submitted on the DentaQuest Provider Appeal Form found in **Attachment F**.

DentaQuest must respond to all provider appeals, in writing, within 30 days.

6.00 Inquiries, Complaints and Appeals

DentaQuest of Illinois, LLC, is committed to providing high quality dental services to all Beneficiaries. As part of this commitment, DentaQuest supports a complaints and appeals protocol assuring that all Beneficiaries have the opportunity to exercise their rights to a fair and expeditious resolution to any and all inquiries, complaints and appeals.

Inquiry

An inquiry is any Beneficiary request for administrative services or information, or an expression of an opinion regarding services or benefits available under the HFS Dental Program.

If specific corrective action is requested by the Beneficiary or determined to be necessary by DentaQuest, then the inquiry is upgraded to complaint.

Complaints

Beneficiaries may submit complaints to DentaQuest telephonically or in writing on any HFS Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues.

DentaQuest must resolve and respond to all Beneficiary complaints within 30 days.

If the Beneficiary chooses to appeal the decision, a Customer Services Representative will assist by providing the information on how to initiate the appeals process.

The toll-free number to call to file a complaint is:

1.888.281.2076

The address to file a complaint is:

DentaQuest of Illinois, LLC
Complaint Representative
12121 North Corporate Parkway
Mequon, WI 53092

Appeals

A. Beneficiary Appeals

Beneficiaries have the right to appeal any adverse decision DentaQuest has made to deny, or reduce dental services.

A Beneficiary may contact his/her caseworker for assistance in filing an appeal. In addition, DHS will help a Beneficiary file an appeal.

Appeals must be filed within 60 days following the date the denial letter was mailed by DentaQuest.

Beneficiaries request a hearing by calling the Fair Hearings Section at 1.800.435.0774 (TTY: 1.312.793.2697 or 1.800.526.0857) or by fax at 1.312.793.2005 or by writing to:

HFS, Bureau of Administrative Hearings
401 South Clinton Street, 6th floor
Chicago, IL 60607

Appeals are reviewed by HFS under its existing administrative appeal procedure, and matters are heard before an Administrative Hearing Officer. DentaQuest approves and allows payment for any services ordered rendered by HFS or any Court of jurisdiction, provided the Beneficiary is eligible.

B. Dentist Appeal Procedures

Providers that disagree with determinations made for Prior Authorization requests may submit a written Notice of Appeal to DentaQuest specifying the nature and rationale of the disagreement. This notice *and* additional support information must be sent to DentaQuest at the address below within 60 days from the date of the original determination to be reconsidered:

DentaQuest of Illinois, LLC
12121 North Corporate Parkway
Mequon, WI 53092
1.888.281.2076
Fax 1.262.241.7401

Provider appeals should be submitted on the form found in **Attachment F**.

DentaQuest must respond to all provider appeals, in writing, within 30 days.

C. Quality Control/Peer Review

DentaQuest facilitates a Peer Review Committee composed of the DentaQuest Dental Director, HFS dental consultants, and a minimum of five participating dentists that submit at least 25 HFS Dental Program claims per year. The Committee evaluates the operational procedures and policies as they affect the administration of the HFS Dental Program. In addition, the Peer Review Committee periodically evaluates the quality of care provided by participating providers.

The Peer Review Committee's recommendations are communicated to providers in a helpful and proactive manner so that questionable practice patterns are eliminated. Thus, the Committee takes corrective action before abuses in the system affect the Beneficiary.

D. Quality Improvement/Utilization Management (QI/UM) Committee

The purpose of DentaQuest's QI/UM Committee is to review data; to assess and evaluate utilization patterns; to advise HFS on dental services policy; to recommend professional education in order to correct identified utilization problems; and to refer to the Peer Review Committee any quality of service care issues identified during utilization review.

7.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations 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.

The 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 DORM reflect the most current coding standards (CDT-2011-2012) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-2011-2012 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form, version 2006 or later.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service Department at 1.888.281.2076 or by e-mailing Customer Service.

Please refer to Attachment J of this manual for DentaQuest's *Companion Guide for 837 Health Care Claim Transactions*.

8.00 Utilization Management Program

8.01 Introduction

The Illinois State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to dentists for treating Illinois HFS Dental Program Beneficiaries. Any co-payments collected by the dentists are not subtracted from the HFS Dental Program fees; therefore, the legislatively appropriated dollars represent all the reimbursement available to the dentists. The fair and appropriate distribution of these limited funds is critical.

8.02 Evaluation

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

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

8.03 Results

With the objective of ensuring the fair and appropriate distribution of these "budgeted" HFS Dental Program dollars to dentists, DentaQuest's Utilization Management Program helps identify dentists whose patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5% of all dentists). DentaQuest is contractually obligated to report suspected fraud, abuse or misuse by Beneficiaries and Participating Dental Providers to the HFS Office of the Inspector General.

8.04 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.

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

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

8.05 Deficit Reduction Act of 2005: The False Claims Act

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. The DRA is a bill designed to reduce federal spending on entitlement programs over five years. The DRA requires that any entity that receives or makes annual Medicaid

payments of a least $5 million establish written policies for its employees, management, contractors and agents regarding the False Claims Act (the “FCA”).

The FCA allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the FCA, the person bringing suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may seek to exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

For more information about the False Claims Act go to the Tax Payers Against Fraud, The False Claims Web site.

DentaQuest is contractually obligated to report suspected fraud, waste or abuse by Beneficiaries and Participating Dental Providers of the HFS Dental Program.

To report suspected fraud, waste or abuse of the HFS Dental Program call:

The Illinois Office of Inspector General at
1.888.814.4646

9.00 Illinois Dental Provider Enrollment Process

DentaQuest does not credential Providers for enrollment in the HFS Dental Program, but all Providers must be registered at DentaQuest in order to submit claims for payment. All Providers must enroll for participation with the State of Illinois, Department of Healthcare and Family Service's Provider Participation Unit before registering at DentaQuest.

Provider enrollment application forms are available on DentaQuest's Web site.

To assist Providers in the enrollment process, you may contact the following in Illinois:

Regional Director of Provider Relations - Illinois/ Statewide	**Provider Relations Representative - Northern Illinois**	**Provider Relations Representative – Central and Southern Illinois**
Colleen Batty	Nick Barnette	Jennifer Straub
Phone: 1-630-790-5008	Phone: 1-800-710-2629	Phone: 1-855-451-8814

Prior to submitting completed Provider applications to the HFS Provider Participation Unit, contact one of the above individuals to ensure that the forms are complete and correct. The application requirements set forth by HFS are specific and stringent – taking the time to contact a Provider Relations Representative ensures that the forms are correct and saves time in the long run.

9.01 Existing Providers

Location Change or Addition – Payee (Billing Address) Unchanged

If the Provider changes locations or adds an additional office location, but the billing address (where checks are mailed) remains unchanged, the Provider must submit notification of the change or addition to DentaQuest. The State of Illinois does not require notification, since the Payee (Tax ID and address) remains unchanged. DentaQuest forwards the notification to the HFS Provider Participation Unit as a courtesy, and it is placed in the Provider's file.

Location Change or Addition – Payee (Billing Address) Change or Addition

If the existing Provider changes locations or adds an additional office location and/or changes the billing address and Tax ID, the HFS Provider Participation Unit must process these changes or additions. Only after the changes or additions are processed by the HFS Provider Participation Unit can DentaQuest enter the changes in its system.

To avoid mistakes and to expedite the process, contact one of DentaQuest's Illinois Provider Relations Representatives (listed above) to initiate payee changes or additions.

9.02 Provider Referral Profile

DentaQuest does not publish a list of participating Providers. As of 2010, the U.S. Department of Health and Human Services does publish a list of providers enrolled in the HFS Dental Program on the Insure Kids Now Web Site. On the Insure Kids Now Web Site it *is* specified, for each provider, whether or not he or she is accepting new patients. This Web site is updated on a monthly basis. Providers are responsible for keeping their information current.

Beneficiaries receive provider referrals by calling DentaQuest's Customer Service toll-free at 1.888.286.2447 or Beneficiaries can access the Provider referral system on the DentaQuest Web site. The referral system works in the following way: Once enrolled, a Provider is added to DentaQuest's GeoAccess Referral Program, which assists a Beneficiary in locating a participating Provider close to his or her home address. Unless notification is received instructing otherwise, a newly enrolled Provider's status is entered

as "Active, Accepting New Patients." DentaQuest's referral system only refers a Beneficiary to a Provider if that Provider is entered as "Active, Accepting New Patients" and if that Beneficiary or referral meets certain criteria which the Provider may specify to DentaQuest. Providers can limit their practices to certain age groups, to certain disabilities, and/or to Beneficiaries requiring specified dental services. In addition, Providers can limit their practices to referrals from a certain provider or from a specified geographic area.

A provider may change his or her referral status with a simple call to DentaQuest's Provider Relations Department at 1.888.875.7482. There is no limit to how often a provider may change his or her referral status

To make referral status changes call:

DentaQuest's Provider Relations Department at 1.888.281.2076.

9.03 Provider Re-enrollment Process

If a provider has not submitted claims in the past 18 months

DentaQuest continually monitors Provider claims submission in conjunction with the State of Illinois' Provider Participation guidelines. A systematic report is generated to determine if a Provider has submitted claims within the last 18 months. If a Provider has not submitted claims, HFS' Provider Participation Unit flags the provider for termination. The following steps are taken to ensure that no Providers are terminated erroneously:

- A report of affected Providers and locations is generated and researched;
- Claims activity is monitored and cross checked between State and DentaQuest systems;
- Provider outreach is initiated to determine if the provider still wishes to participate; and
- The HFS Provider Participation Unit is notified which Providers can be safely terminated and which should remain in the system with active status.

If HFS' Provider Participation Unit initiates a need for updated enrollment forms

HFS' Provider Participation Unit (PPU) initiates a re-enrollment effort on an annual basis. The goal is to refresh each participating Provider's enrollment forms every 5 years. A letter is sent from HFS' Provider Participation Unit during the year explaining the process and requesting that all forms enclosed with the letter are returned to the HFS Provider Participation Unit within a specified time frame. As part of the process two follow-up letters are mailed by PPU to assure that any Provider who wishes to continue his or her participation in the HFS Dental Program (All Kids) has an opportunity to submit the required documentation. If the Provider fails to do so, his/her participation is terminated.

To ensure that Providers interested in continuing participation in the HFS Dental Program are identified, and that those selected for re-enrollment receive support and assistance in completing the re-enrollment process, DentaQuest completes an extensive Provider outreach project consisting of outbound calls and mailers. The goal of the outreach is to provide education about re-enrollment and determine the following:

- Did the Provider receive the re-enrollment materials from HFS (the State)?
- If yes, have they been completed and sent back to HFS?
- If no, does the Provider need a new packet of enrollment materials?

**** If the Provider wishes to continue participation with the HFS Dental Program, all forms must be returned to the HFS Provider Participation Unit (PPU), not DentaQuest. Re-enrollment forms must be completed for each practice location. Providers should keep copies for their records.

*** ***Important *** If the enrollment materials are not completed and returned by July 1st, the Provider is terminated and claims will be rejected.***

10.00 The Patient Record

The following criteria and requirements for the dental patient record apply to both paper and electronic records. Patient records must be kept for a minimum of 10 years, and records pertaining to the most recent 12 months must be available on-site.

A. Organization

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

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

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

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

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

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

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

B. Content – The patient record should be organized in such a fashion to contain the following:

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

   a. Patient's first and last name
   b. Date of birth
   c. Sex
   d. Address
   e. Telephone number

2. Name and telephone number of the person to contact in case of emergency.

3. An adequate health history that documents:

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

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

4. An adequate update of health history at subsequent recall examinations, which documents a minimum of:

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

5. A conspicuously placed medical alert that documents highly significant terms from health history. These items may include:

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

6. Adequate documentation of the initial clinical examination, which is signed and dated by the rendering provider, and describes:

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

7. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations, which is signed and dated by the rendering provider, and describes changes/new findings in these items:

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

8. Radiographs, which are:

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

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

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

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

11. Adequate documentation of the periodontal status, if necessary, which is signed and dated by the rendering provider, and describes:

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

12. Adequate documentation of the patient's oral hygiene status and preventive efforts, which documents:

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

13. Adequate documentation of medical and dental consultations within and outside the practice, which describes:

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

14. Adequate documentation of treatment rendered which verifies the claims submitted, identifying:

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

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

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

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.

2. There is consistent use of each component of the patient record by all staff.

3. The components of the record that are required for complete documentation of each patient's status and care are present.

4. Entries in the records are legible.

5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

11.00 Quality Improvement Program

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to because these standards apply to best practices in the dental service delivery system. The Quality Improvement Program includes:

- Beneficiary Satisfaction Surveys
- Provider Satisfaction Surveys
- Complaint Monitoring and Trending
- Peer Review Process
- Utilization Management and Practice Patterns
- Quarterly Quality Indicator Tracking

A copy of DentaQuest's Quality Improvement Program is available upon request by e-mailing DentaQuest's Customer Service Department or calling 1.888.281.2076.

In establishing criteria for quality dental care and making these characteristics of quality care the standard for review, two types of criteria are involved in developing standards. One type of criteria is **explicit** in nature and is delineated in the written form of Beneficiary treatment protocol and utilization guidelines. The second type of criteria is **implicit** in nature and based on health care procedures and practices which are "commonly understood" to be acceptable and consistent with the provision of good quality care:

- Comparing the care that has actually been rendered with the criteria.
- Making a peer judgment on quality based on the results of the comparison.

As stated previously, Quality Assurance goes beyond measurement and involves the implementation of any necessary changes to maintain and improve the quality of care being delivered including:

- Acting on the result of the evaluation by taking corrective action on any deficiencies noted.
- Assuring that the actions have favorable impact by raising the standards for the dental care delivered.

The purpose of the Quality Improvement Program is to evaluate the quality of dental care being delivered to HFS Beneficiaries and to focus on continuous quality improvement. The goals of the program are to:

- Support the delivery of the highest quality of dental care by the participating dental offices; the primary objective is the Beneficiary's health and welfare.
- Identify any areas of the dental practice that need improvement.
- Provide ongoing feedback to the participating dentists and auxiliary staff.
- Analyze statistical data to assure efficient utilization.

The Quality Improvement Program will utilize accepted standards, guidelines and protocols which have been developed by the federal government, American Academy of Dental Group Practice, the American Dental Association, the American Academy of Pediatric Dentistry, various State Dental Associations and specialty groups.

12.00 All Kids School-Based Dental Program

The HFS Dental Program allows out-of-office delivery of preventive dental services in a school setting to children ages 0–18. This program is called the All Kids School-Based Dental Program.

Recognizing the unique qualities of the All Kids School-Based Dental Program, specific protocols have been developed to assist School-Based Dental Program Providers.

12.01 Participation Guidelines and Forms

Providers who wish to participate as an All Kids School-Based Dental Program Provider must meet the following requirements. Providers who do not adhere to the requirements for participation are not eligible for reimbursement.

1. **All Kids School-Based Dental Program Providers must be enrolled as a participating Provider in the HFS Dental Program.**

   The process for provider enrollment is outlined in Section 9.00.

2. **All Kids School-Based Dental Program Providers must be able to render the full scope of preventive school-based services for an out-of-office setting:**

   - D0120 - Periodic Oral Examination
   - D1120 - Prophylaxis – Child
   - D1203 - Topical Application of Fluoride (excluding prophylaxis) – Child
   - D1206 - Topical Application of Fluoride Varnish
   - D1351 - Sealant – Per Tooth

3. **All Kids School-Based Dental Program Providers must register as an All Kids School-Based Dental Program Provider annually. (Attachment S)**

   Each entity (corporation, partnership, etc.) must register all Providers rendering services for the entity. If a Provider renders services for more than one entity, he/she must be registered under each entity separately.

4. **All Kids School-Based Dental Program Providers must create and maintain a Google Events Calendar. (Attachment T)**

   Each entity must create a Google Event Calendar and provide the user name and password to the DentaQuest Outreach Coordinator. The Google Event Calendar must be populated with at least the first 30 days of school-based events before the All Kids School-Based Dental Program registration is approved.

   The Google Event Calendar must be current and reflect any additions or changes made to the Provider's schedule.

5. **All Kids School-Based Dental Program Providers must complete an Illinois Department of Public Health (IDPH) Proof of School Exam Form for every child seen. (Attachment W)**

   A copy of this form can be found on the IDPH Web site.

   The completed IDPH Proof of School Exam Forms should be forwarded to the school staff member (secretary, principal, school nurse, counselor, etc.) coordinating the All Kids School-Based Dental Program services. The completed forms remain at the school.

*** Office-based providers who complete a school exam on a Beneficiary must complete the school exam form free of charge, if requested by the parent or guardian, within six (6) months of the oral examination.*

6. **All Kids School-Based Dental Program Providers must complete a School Exam Follow-Up Form (to be sent home with the student) for every child seen. (Attachment V)**

   This form shall be completed by the Provider and given to school personnel to communicate with the Beneficiary's parent/guardian regarding the student's oral health and the need for follow-up care.

   The form must provide the Beneficiary's Oral Health Score and the appropriate Referral Plan to provide restorative follow-up care to the Beneficiary (if follow-up care is required).

7. **All Kids School-Based Dental Program Providers must complete a Referral Plan for each location where services are provided. (Attachment U)**

   Each entity is responsible for selecting, implementing and providing a referral plan for each location.

8. **All Kids School-Based Dental Program Providers must complete and submit an Oral Health Score Form listing the Beneficiaries seen at every school-based event to HFS. (Attachment X)**

   To obtain the required Microsoft Excel form electronically, as well as the password required for this password-protected document, please contact the HFS Dental Program coordinator at 1.217.557.5438. HFS will email you the required form.

   This form must include each Beneficiary's Oral Health Score, as assigned on the School Exam Follow-Up Form.

   The password-protected Oral Health Score Form must be submitted electronically to hfs.dental@illinois.gov. within 30 days after the event.

9. **All Kids School-Based Dental Program Providers must complete and maintain a dental record for each Beneficiary receiving school-based services. This record must include relevant components of the Patient Record, as outlined in Section 10.00. (Attachment Z)**

   The All Kids School-Based Dental Provider is responsible for ensuring HIPAA compliant record retention. The location of record retention storage must be provided at the request of HFS.

   The requirements of record retention are outlined in Section 2.00.

10. **All Kids School-Based Dental Program Providers must obtain a signed Consent Form from each Beneficiary prior to providing services. (Attachment Y)**

    The Consent Form must provide information regarding each of the school-based preventive services and must be signed and dated by the Beneficiary's parent/guardian.

An additional consent form must be utilized for those Providers who perform mobile restorative care to children in the All Kids School-Based Dental Program. A sample Consent Form for restorative treatment will not be provided by DentaQuest or HFS.

In accordance with HFS policy, signed Consent Forms are valid for 365 days from the date of parent/guardian signature.

12.02 All Kids School-Based Dental Program Site Visits

On behalf of HFS, the Illinois Department of Public Health (IDPH) performs periodic site visits to providers enrolled as an All Kids School-Based Dental Program Provider.

12.03 Place of Service (POS) Definition

School-based services coded as a POS of school are limited to the five (5) preventive codes.

- D0120- Periodic Oral Examination
- D1120- Prophylaxis – Child
- D1203- Topical Application of Fluoride (excluding prophylaxis) – Child
- D1206- Topical Application of Fluoride Varnish
- D1351- Sealant – Per Tooth

12.04 Designating a POS on a Claim

When filing a claim for **preventive services** performed out-of-office, designate the place of service as follows:

- For paper claims, mark the 'other' box in the place of service field, #38 and, write "school" in the remarks field, #35.
- For electronic claims, in the place of service field, type 03 for school, or 15 for other.

When filing a claim for **restorative services** performed out-of-office, designate the place of service as follows:

- For paper claims, mark the **ECF or Other (If other Note Mobile in remark Box #35)** box in the place of service field, #**38** and, if applicable, put the name of the location where services were performed in the remarks field of #**35**.
- For electronic claims, in the places of service field, **choose the appropriate POS from the drop down menu**.

If claims for services, other than the five (5) preventive services are submitted with a POS of school all services on the claim are denied.

13.00 Clinical Criteria

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

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

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

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

13.01 Criteria for Dental Extractions – Children under age 21 and Adults Age 21 and Older

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs be submitted with the claim for review for payment.

Narrative demonstrating medical necessity may be needed.

Criteria

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

13.02 Criteria for Cast Crowns – Children under age 21, For Adults age 21 and older, limited to facial front teeth only

Documentation needed for authorization of procedure:

- Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs be submitted with the claim for review for payment.

Criteria

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

Authorizations for crowns will not meet criteria if:

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

13.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

- Sufficient and appropriate radiographs such as a pre-operative radiograph of the tooth to be treated such as bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs such as a pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

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

Root canal therapy must meet the following criteria:

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

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

Payment for root canal therapy will **not** be made if any of the following criteria are met:

- Gross periapical or periodontal pathosis is demonstrated radiographically (decay 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.

- Tooth does not demonstrate 50% bone support.

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

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

Other Considerations

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

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

13.04 Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required, the following criteria apply:

Documentation needed for authorization of procedure:

- Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs to be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

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

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

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The permanent tooth must be at least 50% supported in bone.
- Stainless steel crowns on permanent teeth are expected to last, at a minimum, five years.

Authorization and treatment using stainless steel crowns will not meet criteria if:

- A lesser means of restoration is possible.

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

13.05 Criteria for Operating Room (OR) Cases

Criteria

- Young children and\or patients with special needs 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 is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Beneficiary 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, developmental or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

13.06 Criteria for Removable Prosthodontics (Full Dentures for Adults & Children and Partial Dentures for Children only)

Documentation needed for authorization of procedure:

- Appropriate radiographs must be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs to be submitted with the claim for review for payment.
- Within the first six months following insertion of a new prosthesis, any necessary adjustments, relines, and/or rebases are considered part of the insertion process and are the responsibility of the provider.

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement.
- Dentures are only appropriate for patients who can reasonably be expected to coordinate use of prosthesis (i.e. not for those who are comatose or severely handicapped).

Authorizations for Removable prosthesis will **not** meet criteria:

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

- 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 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.

13.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

- The tooth presents with greater than a 75% loss of the clinical crown.

- The tooth has less than 50% bone support.

- The tooth has subosseous and/or furcation caries.

- The tooth is a primary tooth with exfoliation imminent.

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

- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

13.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).

- Narrative describing medical necessity for General Anesthesia or IV Sedation.

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

Criteria

Requests for general anesthesia or IV sedation are reviewed on a case by case basis. Acceptable conditions include, but are not limited to, one or more of the following:

- Documented local anesthesia toxicity.

- Severe cognitive impairment or developmental disability.

- Severe physical disability.

- Uncontrolled management problem.
- Extensive or complicated surgical procedures.
- Failure of local anesthesia.
- Documented medical complications.
- Acute infections.

13.09 Criteria for Periodontal Treatment – Children up to age 21 only

All procedures require authorization.
Documentation needed for authorization of any periodontal procedures:

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

A narrative of medical necessity may be required if the submitted documentation does not support the need for the requested treatment.

Periodontal scaling and root planing -D4341/4342), per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

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

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

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

Criteria

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

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

- Other periodontal procedures will be reviewed for medical necessity and appropriateness of care according to the ADA definitions of code terminology.

13.10 Criteria for Medical Immobilization Including Papoose Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient's record must include:

- Written consent;
- Type of immobilization used;
- Indication for immobilization;
- Duration of application.
- Indication of whether a lesser means of restraint will be possible at the next visit.

Indications

- Patient who requires immediate diagnosis and/or treatment and cannot cooperate due to lack of maturity;
- Patient who requires immediate diagnosis and/or treatment and cannot cooperate due to a mental or physical disability;
- When the safety of the patient and/or practitioner would be at risk without the protective use of immobilization.

Contraindications

Use of this method must not be used:

- With cooperative patients;
- On patients who, due to their medical or systemic condition cannot be immobilized safely;
- As punishment; or
- For the convenience of the dentist and/or dental staff.
- Without a prior attempt to manage the patient without the use of immobilization.

Goals of Behavior Management

- Establish communication
- Alleviate fear and anxiety;
- Deliver quality dental care
- Build a trusting relationship between the dentist and the child and parent; and
- Promote the child's positive attitude towards oral/dental health.

1. Routine use of restraining devices to immobilize young children in order to complete their routine dental care is not acceptable practice and violates the standard of care.

2. Dentists without formal training in medical immobilization must not restrain children during treatment.

3. General dentists without training in immobilization should consider referring to dental specialties those patients who they consider to be candidates for immobilization.

4. Dental auxiliaries must only use medical immobilization devices to immobilize children with direct supervision of a general dentist.

13.11 Criteria for Orthodontic Services – Children up to age 21 only

Documentation

Previously DentaQuest required plaster models, in addition to other required documentation such as x-rays, to review the necessity of the request for orthodontic treatment. DentaQuest now accepts a complete series of intra-oral photos instead of the plaster models. All other required documentation, including panoramic and cepholometric films, tracings, score sheets, and narratives, must be submitted with the photos. This change was made to reduce postage costs for providers, increase the speed with which records are returned, and eliminate the possibility of models being damaged in shipment. If your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:

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

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements. All other currently required documentation, including panoramic and cepholometric x-rays, tracings, narratives, and scoring forms will continue to be required for review.

If your office currently submits digital models through OrthoCad these are still accepted and no change needs to be made regarding the submission of models.

In addition to the photographs and plaster models or digital models, authorization for orthodontic services requires a claim form listing the requested services, the Orthodontic Criteria Index Form (**Attachment G**), and any other documentation that supports medical necessity.

Criteria

- All comprehensive orthodontic services require prior authorization by one of DentaQuest's Dental Consultants.
- An orthodontic patient should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.
- As of July 1, 2010, HFS Dental Program Beneficiaries are evaluated for orthodontic coverage using medical necessity/handicapping criteria as the first level review (**Attachment G**). If the requested orthodontic treatment meets one of the listed criteria, DentaQuest approves the request as meeting medically necessary handicapping criteria.

- If the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form, DentaQuest will proceed with evaluating the request by applying the Salzmann Malocclusion Severity Assessment (**Attachment H**). A patient must score a 42 or higher to qualify for orthodontic services using the Salzmann Malocclusion Severity Assessment, if the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form.

Attachment A

General Definitions

The following definitions apply to this Dental Office Reference Manual:

A. **"Covered Service"** is a dental service or supply that satisfies all of the following criteria:

- provided by an Enrolled Participating Provider to a Beneficiary or by a licensed volunteer dentist through a not-for-profit clinic to a Beneficiary;
- authorized by DentaQuest in accordance with the Provider's Certificate of Coverage; and
- submitted to DentaQuest according to DentaQuest's filing requirements.

B. **"DentaQuest"** shall refer to DentaQuest of Illinois, LLC.

C. **"Enrolled Participating Provider"** is a dental professional or facility or other entity that has entered into a written agreement with HFS through DentaQuest to provide dental services. Any dentist providing services to Beneficiaries of a HFS Medical Benefits Program is required to be enrolled with the Department (89 IL Admin Code 140.23). The provider of service must bill as the treating dentist. The provider of service may elect to be his/her own payee or identify an alternate payee.

D. **"HFS Dental Program"** means dental program administered by HFS for HFS Beneficiaries. When referring to HFS Beneficiaries under age 21, the HFS Dental Program is also referred to as the All Kids Dental Program.

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

F. **"Beneficiary"** means any individual who is enrolled in the Illinois Medicaid or HFS Dental Program.

G. **"HFS"** means Illinois Department of Healthcare and Family Services.

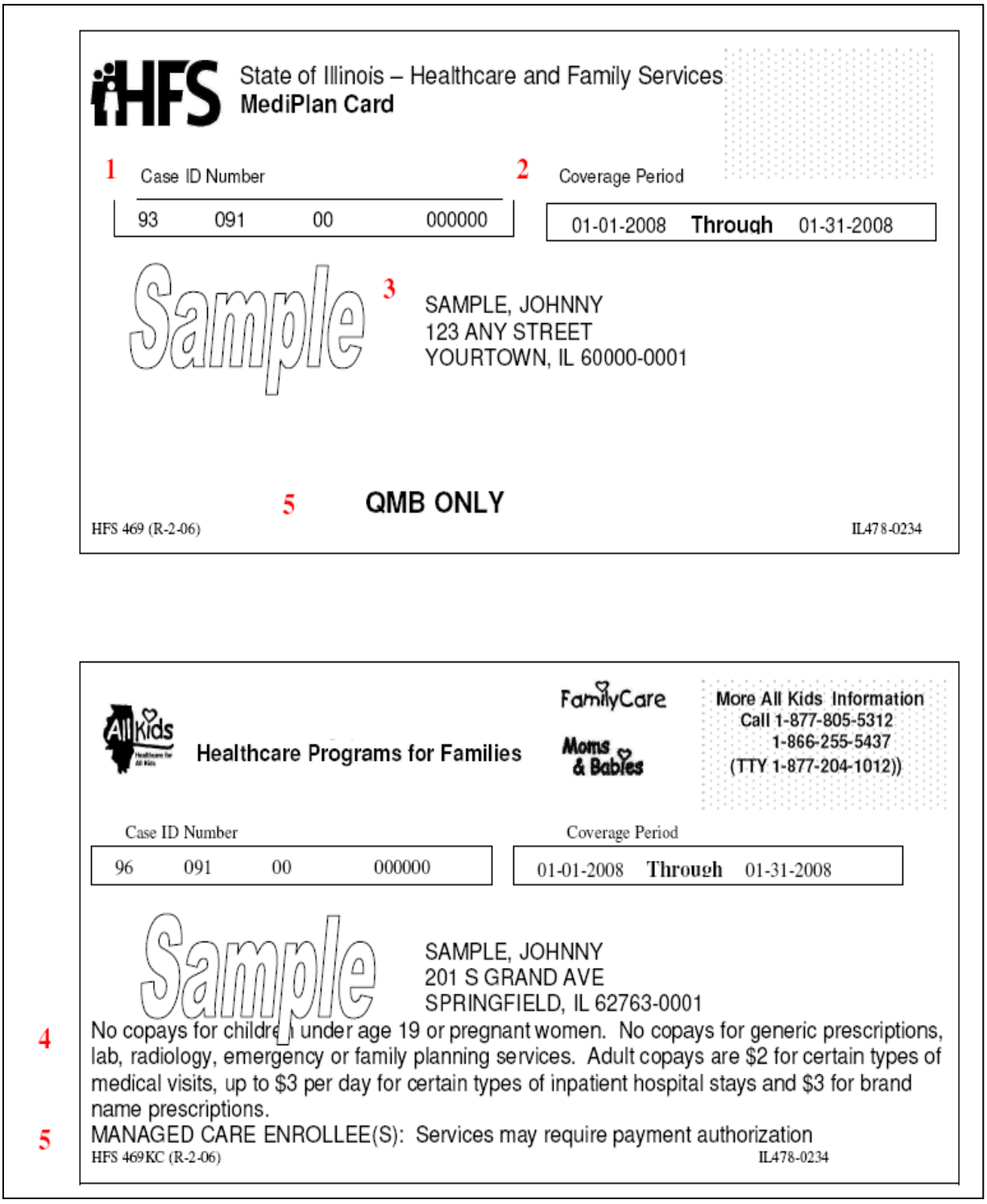
H. **"DHS"** means Illinois Department of Human Services.

I. **"DCFS"** means Illinois Department of Children and Family Services.

J. **"DPH"** means Illinois Department of Public Health.

Attachment B

Healthcare and Family Services Medical Card (Front)



1 Case ID Number

The case identification number identifies the specific case or family unit in which all Beneficiaries listed on the card are included. The case identification number may be used by the provider as a reference when contacting the Department, the local DHS office or the regional DCFS office. This number is not to be used by the provider on billing documents.

2 Eligibility/Coverage Period

The dates listed in this section are the inclusive beginning and end dates of the coverage period documented by the card. Coverage for periods before or after the dates on the card can be verified by contacting DentaQuest's Provider Relations Department at 1.888.281.2076.

3 Case Name and Address

The case name appears in conjunction with the mailing address. It is the main identifier associated with the case identification number. The individual whose name appears as the case name is not eligible for medical services unless the name also is shown in the listing of "eligible persons" on the back of the card. In instances in which a second individual, a bank, an agency or an institution has been designated as guardian, protective payee or representative payee, the applicable name and identifying initials will appear as part of the mailing address.

4 Messages

A variety of explanatory messages may appear in this area. They include such subjects as allowable co-payments and benefit restrictions for certain programs. See 1.01 for limited benefit programs relevant to the HFS Dental Program. A list of messages appears below. An explanation of how the message affects the HFS Dental Program follows each message.

"All Kids Assist, FamilyCare Assist, Moms & Babies
No copays for children under age 19 or pregnant women. No copays for generic prescriptions, lab, radiology, emergency or family planning services. Adult copays are $2 for certain types of medical visits, up to $3 per day for certain types of inpatient hospital stays and $3 for brand name prescriptions. "

This message means that no copayment may be collected for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

"All Kids/FamilyCare Share
Child copays: No copays for immunizations, well-child visits, lab and radiology. $2 for other medical visits. $2 for generic or $2 for brand name Rx, and $2 for non-emergency use of the emergency room. Adult copays: $2 for medical visits, $3 for brand-name Rx and up to $3 per day for hospital stays. No copays for family planning."

This message means that a $2 copayment may be collected for dental services. However, no copayments may be charged for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

"All Kids/FamilyCare Premium Level 1
Child Copays: No copays for immunizations, well-child visits, lab and radiology. $5 for other medical visits, $3 for generic or $5 for brand-name Rx, and $25 for non-emergency use of the emergency room. Adult Copays: $2 for medical visits, $3 for brand-name Rx and up to $3 per day for hospital stays. No copays for family planning."

This message means that a $5 copayment may be collected for dental services. However, no copayments may be charged for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

"FamilyCare Share/Premium
Child copays: No copays for immunizations, well-child visits, lab and radiology. $2 for other medical visits. $2 for generic or $2 for brand name Rx, and $2 for non-emergency use of the emergency room. Adult copays: $2 for medical visits, $3 for brand-name Rx and up to $3 per day for hospital stays. No copays for family planning."

This message means that a $2 copayment may be collected for dental services. However, no copayments may be charged for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

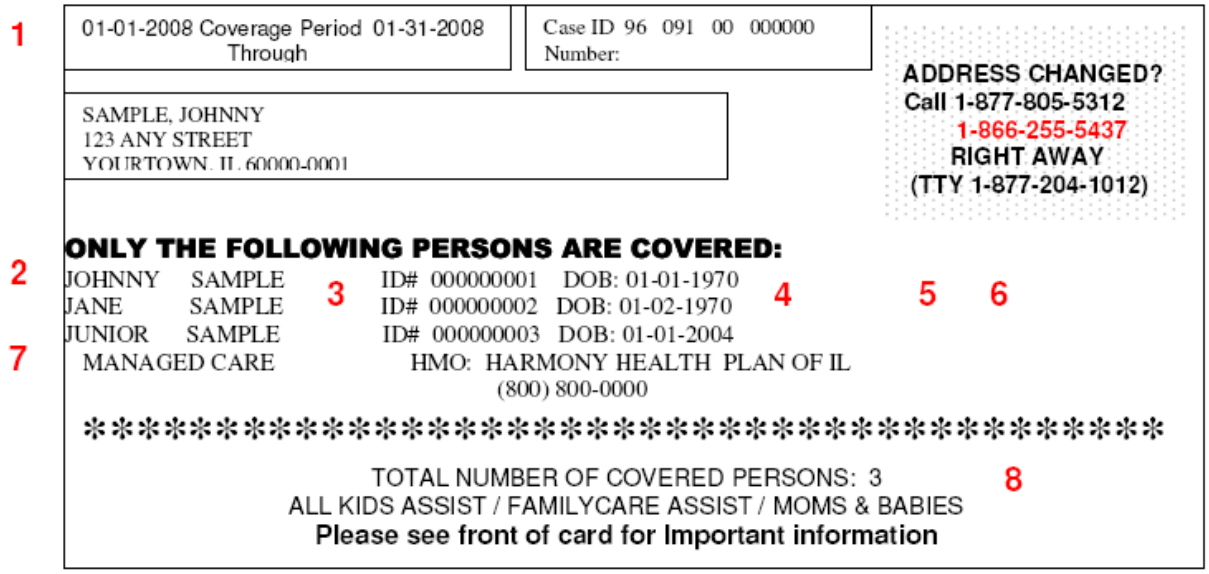
"All Kids Premium Level <#>
Copays apply for most medical services. There are no copays for immunizations for children and well-child visits. To obtain copay status, providers may use the MEDI Web site, a REV vendor, or call 1.800.842.1461, the Automated Voice Response System."

This message means that a copayment commensurate with the All Kids Premium Level may be collected for dental services. The copayment amounts assigned to each All Kids Premium Level are listed in Attachment CC. For example, for "All Kids Premium Level 4", a $20 copayment may be collected for dental services. However, no copayments may be charged for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and X-rays.

5 Special Limitations

This section includes information regarding the "Recipient Restriction Program", "QMB Only", and other information relevant to the Beneficiary's eligibility status.

Healthcare and Family Services Mediplan Card (Back)



1 Items Repeated from the Front of the Card

The Eligibility/Coverage Period, Case ID Number and Case Name and Address which appear on the front of the card also appear in the three boxes on the back of the card.

2 Name of Covered Beneficiaries

The first column in this area shows the name of every covered Beneficiary in the case. The order of the name is first name, middle initial and last name. The name, exactly as shown on the card, of the person to whom services were rendered should be entered as the patient name on the provider's claim.

3 Recipient Identification Number (RIN)

To the right of each covered person's name is the unique, nine-digit Recipient Identification Number for that individual. Each number is valid for only one person. Because this identification number is used to verify eligibility, it is essential that the provider take extreme care when entering the number on the billing form. Use of incorrect numbers is a common cause of billing rejections. It is imperative that the specific number for the patient to whom the medical service was rendered be used on HFS billing forms and on Medicare billing forms if they are expected to electronically cross over to HFS.

4 Date of Birth

The individual's complete birth date appears in the next column. Its form is month (two digits), day (two digits) and year (four digits).

5 Medicare Coverage

The next column to the right identifies Medicare coverage of the individual. An entry will appear in this column only if the Beneficiary has Medicare coverage. If the space in this column is blank, it indicates that neither DHS nor HFS is aware of Medicare eligibility. This does not eliminate the provider's responsibility to inquire about such coverage. The codes which may appear in this column are listed below with the type of coverage:

Code	Type Of Coverage
Part A	Hospital Insurance
Part B	Medical Insurance
Part AB	Both Of The Above

6 Third Party Liability (TPL)

The last column of each line will identify, by code, known third party resources. Information entered here will refer to the Department's record of such resources. The TPL resource code will consist of a three-digit numeric code that may be prefixed with an alphabetic coverage code. The three-digit resource code identifies a specific health insurance company or union fund. The alpha coverage code, if present, indicates the extent of coverage provided by the resource.

Example: A Beneficiary who is insured under a health plan by Aetna Life Insurance Company will have "001" printed in the TPL column of the MediPlan card. The addition of the prefix "A" (A001) will indicate the Beneficiary has a "comprehensive" health plan underwritten by Aetna.

For an explanation of the TPL codes which may appear on the MediPlan Card, refer to General Appendix 9, Third Party Liability Resource Codes, of the Department's *Handbook for Providers of Medical Services*.

The lack of a code in this space means that the Department is not aware of any TPL coverage. It does not eliminate the provider's responsibility to inquire about the possibility of such coverage.

7 Managed Care Organization (MCO) information appears for MCO participants below their name.

8 Total Persons

The total number of persons listed in this line should always match the number of individual Beneficiaries listed above the line.

Attachment C

The Dental Home Concept

Are you building a Dental Home for your patients?

Effective July 1, 2006, the State of Illinois' dental coverage for children expanded under the provisions of the All Kids Program. What was previously known as Medicaid and KidCare was renamed the All Kids Program.

In dentistry, continuity of care is a critical component in ensuring a patient's oral health and well-being. The concept of a Dental Home promotes continuity of care by encouraging dental providers to manage the preventive, the diagnostic and the restorative dental needs of their pediatric patients.

The 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 patients, 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 dentist is not expected to deliver the services, but to coordinate the referral and to monitor the outcome.

The American Academy of Pediatric Dentistry (AAPD) defines dental home as "inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals." It constitutes the ongoing relationship between the dentist who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

Provider support is essential to effectively employ the Dental Home concept with All Kids/HFS Dental Program Beneficiaries. With assistance and support from dental professionals, a system for improving the overall health of children in the All Kids Program can be achieved.

For additional information regarding the All Kids Program, visit the All Kids Web site.

For additional information regarding the Dental Home Concept, visit the American Academy of Pediatrics Healthy Smile Healthy Children Web site.

Attachment D

Dental Claim Form and Instructions

ADA Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

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

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

RECORD OF SERVICES PROVIDED

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

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian signature Date

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

X _____
Subscriber signature Date

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

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

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

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

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

ADA

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

Attachment E

Authorization To Honor Direct Automated Clearing House (ACH) Credits
Disbursed By DentaQuest Of Illinois, LLC

Instructions

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **Important:** Attach voided check from checking account.

Maintenance Type:

_____ Add
_____ Change (Existing Set Up)
_____ Delete (Existing Set Up)

Account Holder Information:

Account Number: _____

Account Type: _____ Checking

_____ Personal _____ Business (choose one)

Bank Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest of IL, LLC** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

_____ Date

_____ Print Name

_____ Phone Number

_____ Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

_____ Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

Tax Id (As appears on W-9 submitted to DentaQuest)

Attachment F
DentaQuest Provider Appeal Form

Mail completed forms to:
DentaQuest
Attn: Provider Appeals
12121 N. Corporate Pkwy.
Mequon, WI 53092
Fax 1.262.834.3452

Beneficiary Name: _____

Member Identification Number: _____

Date of Service: _____

Date EOB was received: _____

Authorization Number: _____

Date Authorization was received: _____

- -

Provider Name: _____

Location Number: _____

Name of Office Contact: _____

Office Phone Number: _____

- -

Reason for Appeal:

_____
_____
_____
_____
_____
_____

Requested Outcome:

_____
_____
_____
_____

Attachment G

DentaQuest

First Review ___IL HFS Dental Program
Second Review ___

Models ___
Orthocad ___
Ceph Films ___
X-Rays ___
Photos ___
Narrative ___

DENTAQUEST
ORTHODONTIC CRITERIA INDEX FORM – COMPREHENSIVE D8080

Patient Name: _____ DOB:_____

ABBREVIATIONS	CRITERIA for Permanent Dentition	YES	NO
DO	Deep impinging overbite that shows palatal impingement causing tissue trauma with the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted and not correctable by habit therapy).		
AP	Demonstrates a large anterior –posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III).		
AX	Anterior crossbite. (Involves more than two teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited ortho treatment)		
PX	Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar and not correctable by limited ortho treatment).		
PO	Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy.).		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
CR	Crowding of 7 – 8 mm in either the maxillary or mandibular arch.		
OJ	Overjet in excess of 9 mm.		
CDD	Dentition exhibits a profound impact from a congenital or developmental disorder.		
FAS	Significant facial asymmetry requiring a combination orthodontic and orthognathic surgery for correction.		

Approved ☐

When all are answered "NO", please refer to the Salzmann ☐

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS
Richard Nellen, DDS Paul Schulze, DDS B.N. Marchese, DDS Scott Charmoli, DDS

First Review____
Second Review____

Models ____
Orthocad ____
Ceph Film ____
X-Rays ____
Photos ____
Narrative ____

Attachment H

Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

Beneficiary Name: _____ Date of Birth: _____

Case Name: _____ Dentist's Name: _____

Examiner: _____ Date: _____

Records Received:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

Quality:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

A. INTRA-ARCH DEVIATION

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post			0				X1	

Total Score _____

Ant = anterior teeth (4 incisors)
Post. = posterior teeth (Include canine, premolars and first molar).
No. = number of teeth affected
P.V. = point value

B. Inter-Arch Deviation

2 Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	P.V.	Score
						X2	

Total Score _____

*Score maxillary or mandibular incisors.

2. Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
	Distal		Mesial		Crossbite		Openbite				
	Right	Left	Right	Left	Right	Left	Right	Left			
Canine											
1st Premolar											
2nd Premolar											
1st Molar											

Total Score _____

Add 8 points when intra-and intra-arch maxillary incisors score if 6 or more to denote esthetic handicap..... _____

Grand Total _____

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with malocclusion: **Score 8 points for each deviation.**

1. Facial and oral clefts		
2. Lower lip palatal to maxillary incisor teeth		
3 Occlusal interference		
Possible Surgical Indication	4 Functional jaw limitations	
Yes No	5. Facial asymmetry	
5 Speech impairment		TOTAL SALZMANN INDEX:
6 Total Score		

Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

Summary of instructions

Score: 2 points for each maxillary anterior tooth affected.
1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
    a. Open spacing. One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth.
    b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially eruption.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the “Handicapping Malocclusion Assessment Record”

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

A. Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: **A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.**

a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.

d. Spacing

(1) Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).

(2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: **A value of 1 point is scored of each tooth affected.**

a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.

d. Spacing

(1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).

(2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. Interarch Deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.

    a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.

    b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.

    c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

    d. Open-bite refers to vertical interach dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.

    a. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.

    b. Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.

    c. Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with a malocclusion: Score eight (8) points for each deviation.

1. Facial and oral clefts.
2. Lower lip positioned completely palatal to the maxillary incisor teeth.
3. Occlusal interference that cannot be corrected by a less intrusive therapy.
4. Functional jaw limitations.
5. Facial asymmetry to the extent that surgical intervention is indicated.
6. Speech impairment documented by a licensed or certified therapist whose cause is related to the improper placement of the dental units.

DentaQuest

Attachment I

OrthoCAD Submission Form

Date:_____

Patient Information		
Name (First & Last)	**Date of Birth:**	**SS or ID#**
Address:	**City, State, Zip**	**Area code & Phone number:**
Group Name:	**Plan Type:**	

Provider Information		
Dentist Name:	**Provider NPI #**	**Location ID #**
Address:	**City, State, Zip**	**Area code & Phone number:**

Treatment Requested

Code:	**Description of request:**

Attachment J

HIPPA Companion Guide

DentaQuest
837 Dental Companion Guide

Table Of Contents

1.0 Introduction

Section 1.1 What Is HIPAA?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting standards will eventually improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in healthcare. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards. The standards were not imposed by the law, but instead were developed by a process that included significant public and private sector input. Covered entities are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically.

Additional HIPAA Requirements

- Privacy: Standards must be adopted by all health plans, clearinghouses, and providers to ensure the protection and appropriate disclosure of individually identifiable health information.
- Security: Standards must be adopted by all health plans, clearinghouses, and providers to ensure the integrity and confidentiality of healthcare information. The security rule addresses healthcare information in all types of media, including hard copy and electronic.
- National Identifier Codes: Standards must be adopted by all health plans, clearinghouses, and providers regarding unique identifiers for providers, plans, employers, and individuals (beneficiaries).
- Enforcement: The Office of Civil Rights has been appointed to enforce the privacy rule and has been given the authority to levy penalties for compliance failures. CMS has been designated to monitor the transaction and code sets compliance.

Although this Companion Guide deals with only one aspect of the entire “Administrative Simplification” provision, it is worth noting that all covered entities (health plans, clearinghouses, and providers) and their business partners are required to adhere to all aspects of the provision.

Section 1.2 Purpose of the Implementation Guide

The Implementation Guide specifies in detail the required formats for the electronically submitted transaction from a provider to an insurance company, healthcare payer or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within the segments, and was written for all healthcare providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files.

Section 1.3 How to Obtain Copies of the Implementation Guides

The implementation guides for X12N 837 Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA

Section 1.4 Purposes of this Companion Guide

This Companion Guide was created for trading partners to supplement the 837D Implementation Guide. It contains specific information for the following:

- data content, codes, business rules, and characteristics of the transaction;
- technical requirements and transmission options; and
- information on test procedures that each Trading Partner must complete prior to submitting production 837D transactions to DentaQuest.

This guide is specific to electronic interfaces with DentaQuest. The information in this guide supersedes all previous communications from DentaQuest about this electronic transaction.

Section 1.5 Intended Audience

The Companion Guide transaction document is intended for the technical staff of the external entities that will be responsible for the electronic transaction/file exchanges with DentaQuest. The Companion Guide is available to external entities (providers, third party processors, clearinghouses, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with DentaQuest.

Section 1.6 Introduction to the 837 Dental Healthcare Claims Transaction

The 837 transactions under HIPAA is the standard for electronic exchange of information between two parties to carry out financial activities related to a health care claim. The health care claim or equivalent encounter information transaction is the transmission of either of the following:

- A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
- If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

The 837 Health Care Claim transaction set can be used to submit health care claim billing information, encounter information, or both. It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits are required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists and pharmacies and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance benefit. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

This document consists of situational fields for the following transaction type that are required for processing DentaQuest Medicaid Dental claims; however, this document is not the complete EDI transaction format. This companion guide is based on the transaction implementation guide, version:

Dental Transaction ASC X12N 837(004010X097A1)

2.0 Trading Partners

Section 2.1 General Overview

All entities desiring to be a Trading Partner must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile Form for each business entity. To obtain the TPA and

Profile Form please contact Customer Service at 1-800-341-8478. Please note that the profile information may be given over the telephone in lieu of completing a paper form. DentaQuest will assign a Trading Partner ID for your use in electronic transaction exchange and login into DentaQuest's Trading Partner Web Portal.

Section 2.2 Establishing Connectivity

DentaQuest will maintain various methods of exchanging EDI information. DentaQuest has created a Trading Partner Web Portal to allow trading partners to exchange Dental Claim transactions and this is the preferred method of facilitating EDI exchange. The portal allows a Trading Partner to submit and receive transactions. Outgoing transmissions, including all response transactions and functional acknowledgments will be available only through the Trading Partner Web Portal. Other Trading Partner submission methods include SSL FTP. Contact Customer Service at 1-800-341-8478 with questions about these options.

Encryption is handled automatically as part of SSL (Secured Socket Layer) for the Web Portal or FTP session upon login. Data that pass through the SSL session are encrypted using a 128-bit algorithm and managed via The Verisign $_{tm}$ Secure Site Program.

Section 2.3 Trading Partner Testing

Prior to submitting production 837D claims, the Trading Partner must complete testing. Testing includes HIPAA compliance as well as validating the use of conditional, optional and mutually defined components of the transaction. Contact Customer Service at 1-800-341-8478 to discuss the transmission method, testing process and criteria.

- Test files should contain as many types of claims as necessary to cover each of your business scenarios (original claims, void claims, replacement claims (see Section 6.0 for specific data requirements).

DentaQuest will process these test claims in a test environment to validate that the file meets HIPAA standards and specific data requirements. Once the testing phase is complete and DentaQuest has given its approval, the Trading Partner may submit production 837D transactions to DentaQuest for adjudication. Test claims will not be adjudicated.

3.0 Technical Requirements

Section 3.1 File Size

For 837D transactions, DentaQuest is imposing a limit of 50,000 claim transactions per submission. If you have any questions or would like to coordinate the processing of larger files, please contact Customer Service at 1-800-207-5019.

Section 3.2 Naming Convention

Trading Partner Web Portal users may use any convenient file naming convention for their 837D files claims transmitted to DentaQuest. DentaQuest's system will rename files upon receipt and issue a confirmation number for reference. FTP submitted files must adhere to the following naming convention:

Naming Convention: **P837D_20001_20061010_001**
P – indicates whether this is a production or test (**T**) file
837D – indicates the transaction type
200001 – indicates the 6 digit trading partner ID
20061023 – indicates the date the file was sent (YYYYMMDD)
001 – indicates the sequence number of the file, incremented for subsequent submissions on the same day

Section 3.3 Multiple Transactions Types In a File

DentaQuest does not allow multiple transaction types to be submitted within a single file submission. While the X12 standards do support the handling of multiple transaction set types to be submitted in a single file (ex. 837D and 276), DentaQuest will not support transaction bundling within a file. Transactions types must be sent separately.

Section 3.4 Balancing Data Elements

DentaQuest will use any balancing requirements that can be derived from the transaction implementation guides. All financial amount fields must be balanced at all levels available within the transaction set. The number of transactions in the header and footer must equal and be the same as the number of transactions in the file.

4.0 Acknowledgments

Section 4.1 Functional Acknowledgment Transaction Set (997)

DentaQuest uses the 997 transaction to acknowledge receipt of 837D files. The 997 acknowledgements will be available for download from the Trading Partner Web Portal.

The 997 Functional Acknowledgment Transaction is designed to check each functional group in an interchange for data and syntax errors and send results back to the sending trading partner. The 997 can accept or reject records at the functional group, transaction set, or data element level. DentaQuest's 997 Functional Acknowledgment Transaction will report acceptance or rejection at the functional group and transaction set levels.

5.0 Support Contact Information

DentaQuest Government Customer Service phone number: 1-800-341-8478 or e-mail DentaQuest.

6.0 Specific Data Requirements

The following sections outline recommendations, instructions and conditional data requirements for submitting 837D transactions to DentaQuest.

Section 6.1 Claim Attachments

An electronic standard for claim attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, DentaQuest has an alternative method for handling electronic claims that require attachments. If you are enrolled and are using the service offered by National Electronic Attachments (NEA), DentaQuest can accept the assigned NEA control/tracking number when reported in the notes segment (NTE segment). For more information about using NEA to submit electronic attachments contact Customer Service at 1-800-207-5019 or you may visit the NEA Web site or by calling 1-800-482-5150.

Section 6.2 Predeterminations

DentaQuest will not accept Predetermination of Benefits Claims.

Section 6.3 Coordination of Benefits (COB) Claims

Submit by paper with primary carrier explanation of benefits attached.

Section 6.4 Void Transactions

Void transactions are used by submitters to correct any of the following situations:

- Duplicate claim erroneously paid
- Payment to the wrong provider
- Payment for the wrong member
- Payment for overstated or understated services
- Payment for services for which payment has been received from third-party payers

Void transactions must be submitted for each service line at a time. For example, if a provider wishes to void a claim that was originally submitted with three service lines, the provider must submit three void transactions. Each transaction is for one of the service lines and must include the original generated DentaQuest Claim Encounter Number (CLP07 from the 835 or Encounter # from paper remittance advice)

Section 6.5 Detail Data

Submitters can view the entire set of required data elements in the 837D Implementation Guide. It is recommended that submitters pay special attention to the following segments:

6.5.01 Control Segments

X12N EDI Control Segments
ISA-Interchange Control Header Segment
IEA-Interchange Control Trailer Segment
GS-Functional Group Header Segment
GE-Functional Group Trailer Segment
TA1-Interchange Acknowledgment Segment

6.5.02 ISA – Interchange Control Header segment

Reference	Definition	Values
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	[space fill]
ISA03	Security Information Qualifier	00
ISA04	Security Information	[space fill]
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	[DentaQuest-assigned 6 digit Trading Partner ID]
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	DDS391933153
ISA09	Interchange Date	The date format is YYMMDD
ISA10	Interchange Time	The time format is HHMM
ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	1
ISA15	Usage Indicator	T=Test P=Production
ISA16	Component Element Separator	: (Colon)

6.5.03 IEA – Interchange Control Trailer

Reference	Definition	Values
IEA01	Number of included Functional Groups	Number of included Functional Groups
IEA02	Interchange Control Number	Must be identical to the value in ISA013

6.5.04 GS-Functional Group Header

Reference	Definition	Values
GS02	Application Sender's Code	Must be identical to the values in ISA06
GS03	Application Receiver's Code	DDS391933153
GS04	Date	The date format is CCYYMMDD
GS05	Time	The time format is HHMM
GS06	Group Control Number	Assigned and maintained by the sender
GS07	Responsible Agency Code	X
GS08	Version/Release/Industry Identifier Code	004010X097A1 (Addenda Versions must be used)

6.5.05 GE-Functional Group Trailer

Reference	Definition	Values
GE01	Number of Transactions Sets Included	Number of Transaction Sets Included
GE02	Group Control Number	Must be identical to the value in GS06

6.5.06 Preferred Delimiters

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	123	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6.5.07 Segment Definitions

ISA - Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

IEA - Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange -related control segments. This segment may be thought of traditionally as the file trailer record.

GS - Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

GE - Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of

transactions. This segment may be thought of traditionally as the batch trailer record.

ST - Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

SE - Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

6.5.08 837 Dental Healthcare Claim Transaction

Special attention should be given to the following required segment detail.

Field Definition

Column

A. The name of the loop as documented in the appropriate 837 Implementation Guide.
B. Loop ID used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837 Implementation Guide.
C. The field position number and segment number as specified in the appropriate 837 Implementation Guide.
D. The data element name and page number as indicated in the appropriate 837 Implementation Guide.
E. The Values and Comments further describe the appropriate 837 Implementation Guide Field data that DentaQuest will accept for processing a claim.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Beginning of Hierarchical Transaction		010-BHT02	Transaction Set Purpose Code Pg 55	'00' Original
Beginning of Hierarchical Transaction		010-BHT-06	Transaction Type Code Pg 56	'CH' Chargeable
Submitter Name	1000A	020-NM109	Identification Code Pg 61	[DentaQuest assigned 6 digit Trading Partner ID]
Submitter Contact Information	1000A	020-PER05	Communication Number Pg 65	'TE' Telephone
Receiver Name	1000B	020-NM103	Name Last or Organization Pg 67	DentaQuest Dental Services

Loop Name	Loop ID	837 Field Position &	837 Data Element Name & Page	Valid Values & Comments

		Segment	Number from Imp Guide	
A	**B**	**C**	**D**	**E**
Receiver Name	1000B	020-NM109	Identification Code Pg 67	DDS391933153
Billing Provider Name	2010AA	015-NM101	Entity Identifier Code Pg 77	'85' Billing Provider
Billing Provider Name	2010AA	015-NM102	Entity Type Qualifier Pg 77	'1' Person '2' Non-Person Entity
Billing Provider Name	2010AA	015-NM103	Billing Provider Name Pg 77	Last Name or Organizational Name
Billing Provider Name	2010AA	015-NM104	Billing Provider Name Pg 77	If NM102= 1, First Name
Billing Provider Name	2010AA	015-NM108	Identification Code Qualifier Pg 78	'XX' National Provider Identifier
Billing Provider Name	2010AA	015-NM109	Identification Code Pg 78	Billing Provider National Provider Identifier
Billing Provider Address	2010AA	025-N301	Address Information Pg 80	Rendering Location Address Line
Billing Provider City/State/Zip Code	2010AA	030-N401	City Name Pg 81	Rendering Location City Name
Billing Provider City/State/Zip Code	2010AA	030-N402	State or Province Code Pg 82	Rendering Location State
Billing Provider City/State/Zip Code	2010AA	030-N403	Postal Code Pg 82	Rendering Location Zip Code (report Zip plus 4)
Billing Provider Secondary Identification Number	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'TJ' Federal Taxpayer's Identification or 'SY' Social Security Number or 'EI' Employer Identification Number
Billing Provider Secondary Identification Number	2010AA	035-REF02	Reference Identification Pg 84	Federal Taxpayer's Identification or Social Security Number or Employer Identification Number

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Pay to	2010AB	015-NM101	Entity Identifier Code	'87' Pay-to-Provider

Provider's Name			Pg 88	
Pay to Provider's Name	2010AB	015-NM102	Entity Type Qualifier Pg 88	'1' – Person '2' – Non-Person Entity
Pay to Provider's Name	2010AB	015-NM103	Name Last or Organization Name Pg 88	Pay-to-Provider Last Name or Organization Name
Pay to Provider's Name	2010AB	015-NM104	Name First Pg 88	If NM102=1, Pay-to-Provider First Name
Pay to Provider's Name	2010AB	015-NM108	Identification Code Qualifier Pg 89	'XX' National Provider Identifier
Pay to Provider's Name	2010AB	015-NM109	Identification Code Pg 89	Pay-to-Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI from 2010AA is used as the pay-to-provider
Pay to Provider's Address	2010AB	025-N301	Address Information Pg 91	Pay-to Provider Address Line
Pay to Provider City/State/Zip	2010AB	030-N401	City Name Pg 92	Pay-to Provider City
Pay to Provider City/State/Zip	2010AB	030-N402	State or Province Code Pg 93	Pay-to-Provider State
Pay to Provider City/State/Zip	2010AB	030-N403	Postal Code Pg 93	Pay-to-Provider Zip Code (report Zip plus 4)
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Qualifier Pg 95	'TJ' Federal Taxpayer's Identification Number of 'SY' Social Security Number or 'EI' Employer Identification Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Qualifier Pg 95	Federal Taxpayer's Identification Number or Social Security Number or Employer Identification Number

Loop Name	**Loop ID**	**837 Field Position & Segment**	**837 Data Element Name & Page Number from Imp Guide**	**Valid Values & Comments**
A	**B**	**C**	**D**	**E**
Subscriber Hierarchical Level	2000B	001-HL04	Hierarchical Level Page 97	0-No Subordinate HL Segment in the Hierarchical Structure
	2000B	005-SBR01	Payer Responsibility	T-Tertiary

Subscriber Information			Sequence Number Code Pg 99	
Subscriber Information	2000B	005-SBR09	Claim Filing Indicator Code Pg 102	'MC' Medicaid
Original Reference Number	2300	180-REF01	Reference Identification Qualifier Pg 180	'F8' Original Reference Number
Original Reference Number	2300	180-REF02	Claim Original Reference Number Pg 180	For Claim Frequency Type Code 7 (Replacement Claim) or 8 (Void), report original DentaQuest Encounter Identification Number (CLP07 from the 835 or Encounter # from paper remittance)
Rendering Provider Name	2310B	250-NM101	Entity Identifier Code Pg 196	'82' Rendering Provider
Rendering Provider Name	2310B	250-NM102	Entity Type Qualifier Pg 196	'1' Person
Rendering Provider Name	2310B	250-NM103	Name Last or Organization Name Pg 196	Rendering Provider Last Name
Rendering Provider Name	2310B	250-NM104	Name First Pg 196	Rendering Provider First Name
Rendering Provider Name	2310B	250-NM108	Identification Code Qualifier Pg 197	'XX' National Provider Identifier
Rendering Provider Name	2310B	250-NM109	Identification Code Pg 197	Rendering Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI number from 2010AA is used as the rendering provider.

Loop Name	**Loop ID**	**837 Field Position & Segment**	**837 Data Element Name & Page Number from Imp Guide**	**Valid Values & Comments**
A	**B**	**C**	**D**	**E**
Service Facility Location	2310C	250-NM108	Identification Code Qualifier Pg 204	XX' Health Care Financing Administration National Provider Identifier
Service Facility Location	2310C	250-NM109	Identification Code	NPI reflecting rendering location if you have enumerated.

				(Typically the Subpart NPI)

7.0 Appendix A: Links To Online HIPAA Resources

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

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. Visit the ASC X12 Web site for more information.

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. Visit the ADA Web site for more information.

Association for Electronic Health Care Transactions (AFEHCT)

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

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan on the CMS Web site.
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision.

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. Visit the DSMO Web site for more information.

Office for Civil Rights (OCR)

- OCR is the office within US Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. Visit the DHHSOCR Web site for more information.

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. Visit the DHHS Web site for more information.

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. Visit the WPC Web site for more information.

Workgroup for Electronic Data Interchange (WEDI)

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

Attachment K

Patient Recall System Recommendations

Recall System Requirements

Each participating office should 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 Beneficiary that has sought dental treatment.

Office Compliance Verification Procedures

In conjunction with its office claim audits described in section 5, DentaQuest will measure compliance with the requirement to maintain a patient recall system.

Participating dentists are expected to meet minimum standards with regard to appointment availability. Emergent situations (those involving pain, infection, swelling and/or traumatic injury) need to be appointed within 24 hours. Urgent care should be available within 72 hours. Initial and Recall routine treatment should be scheduled within 30 days of initial contact with the dentist's office. Follow-up appointments should be scheduled within 45 days of the present treatment date. Providers should see a Beneficiary within 30 minutes of arriving at the office for a scheduled appointment.

Attachment L

Office Claim Audit

A. Purpose

DentaQuest utilizes a proprietary paperless process to collect procedure information and determine the value of services rendered by each participating office. Additionally, DentaQuest has substituted specific dental treatment protocols and related documentation requirements for prior-authorization procedures utilized by many traditional dental PPOs.

The resulting streamlined process greatly reduces the administrative burden of DentaQuest's participating dentists by recognizing the fundamental difference between monitoring necessary and appropriate dental services and traditional medical utilization management.

Despite the obvious benefits of the streamlined process, DentaQuest's paperless system could potentially be abused by fraudulent claim entry. In order to assure its dental panel Beneficiaries that such efforts will be identified and appropriately dealt with, DentaQuest has designed a fraud detection program that provides a 98% probability of detecting fraudulent claim submission.

B. Random Chart Audits

On a periodic basis, DentaQuest takes a sample of claims submitted by selected office locations. DentaQuest provides this listing of Beneficiaries and dates of service to the office location. For each Beneficiary and date of service, the office must supply complete dental records to support the services billed. These records will be reviewed to ensure compliance with the Beneficiary record protocols, as well as to detect possible billing irregularities.

Each office may either make copies of the records requested or arrange for a DentaQuest representative to review the original records at the office location itself.

DentaQuest claim audits will be scheduled on a random basis. DentaQuest shall make every effort to schedule these reviews at times that are convenient for the office and will make every effort to complete the review in as short a duration as is practical.

Attachment M

Radiology Guidelines

Note: Please refer to benefit tables for benefit limitations.

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

A. Radiographic Examination of the New Patient

Child – Primary Dentition

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

Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal examination with Posterior Bitewings OR a Panoramic X-ray and Posterior Bitewings, for a new patient with a transitional dentition.

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

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

Adult – Dentulous

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

Adult – Edentulous

The Panel recommends a Full-Mouth Intraoral Radiographic Survey or a Panoramic X-ray for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

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

a. Child – Primary and Transitional Dentition

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

b. Adolescent

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

c. Adult – Dentulous

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

d. Adult – Edentulous

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

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

a. Child – Primary Dentition

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

b. Adolescent

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

c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

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

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

4. Growth and Development Assessment

Child – Primary Dentition

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

Child – Transitional Dentition

The Panel recommended and individualized Periapical/Occlusal series OR a Panoramic X-ray to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

Adolescent

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

Adult

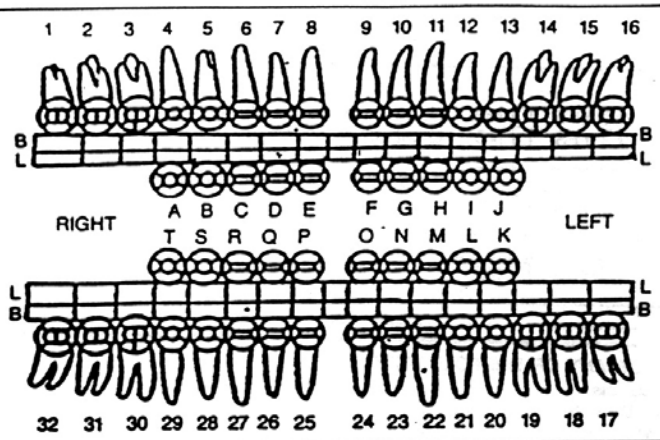
The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

Attachment N

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

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

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

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

Attachment O

Recall Examination

Patient's Name _____

Changes In Health Status/Medical History _____

	Ok		Ok	Clinical Findings/Comments
Lymph Nodes		TMJ		
Pharynx		Tongue		
Tonsils		Vestibules		
Soft Palate		Buccal Mucosa		
Hard Palate		Gingiva		
Floor Of Mouth		Prosthesis		
Lips		Perio Exam		
Skin		Oral Hygiene		

Radiographs	B/P	RDH/DDS

R **Work Necessary** **L**

Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments: _____

_____

_____

Recall Examination

Patient's Name _____

Changes In Health Status/Medical History _____

	Ok		Ok	Clinical Findings/Comments
Lymph Nodes		TMJ		
Pharynx		Tongue		
Tonsils		Vestibules		
Soft Palate		Buccal Mucosa		
Hard Palate		Gingiva		
Floor Of Mouth		Prosthesis		
Lips		Perio Exam		
Skin		Oral Hygiene		

Radiographs	B/P	RDH/DDS

R **Work Necessary** **L**

Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments: _____

_____

_____

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

Attachment P

Authorization for Dental Treatment – Sample

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

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

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

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

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

Attachment Q

Medical And Dental History – Sample Form

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: _____

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

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

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

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

Patient Signature : _____ Date : _____

Dentist's Signature : _____ Date : _____

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

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

Attachment R

Agreement to Pay Non-Covered Services

Patient Name: _____

Recipient (Medicaid) ID: _____

Guarantor Name: _____

Relationship to Patient: _____

Not all dental services are covered by the HFS/All Kids Dental Program. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above named patient, but are not covered services:

Non-Covered Services

Code	Description

I understand that the above services are not covered by the HFS/All Kids Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

_____ _____

Guarantor Signature Date

Guarantor Address: *Guarantor Phone*

_____ Home: _____

Street, Apt # Cell: _____

_____ Work _____

City, State, Zip

Attachment S
Illinois All Kids School-Based Dental Program
Provider Registration

DentaQuest of Illinois, LLC
1100 South Fifth Street, Springfield, IL 62703
Attn: Illinois Outreach Coordinator
Fax (217) 522-8851

****Incomplete Applications Will Delay the Approval Process****

Providers must complete and submit the following documents in order to participate in the Illinois **All Kids School-Based Dental Program:**

____1. A **completed** All Kids School-Based Dental Program Provider Registration Application (page 99) and the Certification, Statements, and Signature form (page 100).
____2. A copy of the **Referral Plan,** with one of the required options chosen, for every community serviced in the All Kids School-Based Dental Program.

The following items are **required** on an on-going basis upon completion of school-based exams:

____1. A **completed** IDPH Proof of School Dental Examination Form.
____2. A **completed** School Exam Follow-Up Care Form (including the Referral Plan information, if necessary) to be sent home with the student.
____3. A **completed** Dental Record for every All Kids Dental Program Beneficiary who received school-based services.
____4. A roster of the students who are Beneficiaries of the All Kids Dental Program receiving care, including Oral Health Scores, password protected via e-mail to HFS.dental@illinois.gov
____5. The Google Events Calendar which must be **current** at all times.

Please remember:
Providers cannot be paid for school-based services rendered to Beneficiaries until final approval from DentaQuest is received. This process will take approximately 2-4 weeks.

Audits may be conducted to prove best efforts have been made by the school provider to ensure that Beneficiaries are receiving necessary follow-up.

Site visits will be conducted by the Illinois Department of Public Health on behalf of the Department of Healthcare and Family Services.

Illinois All Kids School – Based Dental Program

Provider Registration Application

School Based Provider Entity Name		Phone #:
Billing Office Contact Name	E-Mail Address:	Fax #:

Billing Office Address	City	State	Zip Code

Office Information

Participating School Providers	Individual NPI	Dentist Signature

Illinois All Kids School-Based Dental Program
Certification, Statements, and Signature

I hereby acknowledge that the information provided in this application is material to the determination by DentaQuest whether or not to execute my request. I hereby represent and warrant that all information provided herein is true to the best of my knowledge, and I agree to notify DentaQuest in the event an error is discovered or when new events occur which alter the validity of any response herein. I also agree to supply all necessary member information required to HFS in a timely manner upon completion of each event.

I certify that:

- All services are provided by and under the supervision of a licensed dentist.
- The above information is complete, correct and true to the best of my knowledge.

Signed by: _____ Date: _____
Entity's Owner or Owner's Designee

Please print name: _____

All applications are subject to review and approval by DentaQuest.

Information contained will be held in strict confidence, and available for review by only duly authorized employees of DentaQuest of IL, LLC, the Department of Healthcare and Family Services, or the Illinois Department of Public Health. Any corrections, additions, or clarification to these files must be submitted in writing to the DentaQuest Outreach Coordinator. The practitioner has the right, upon request, to be informed of the status of their application via phone, fax, or e-mail.

Attachment T
Illinois All Kids School-Based Dental Program
Google Events Calendar

The Google Events Calendar is required by each All Kids School-Based Dental Program Provider/entity. The calendar is a real-time communication to relay the scheduled school-based events. The schedule must be current at all times.

Please Remember:

Submission of the Provider/entity school-based schedules will not be accepted in any other format.

A minimum of the first 30 days schedule must be completed before the All Kids School-Based Dental Program registration can be approved.

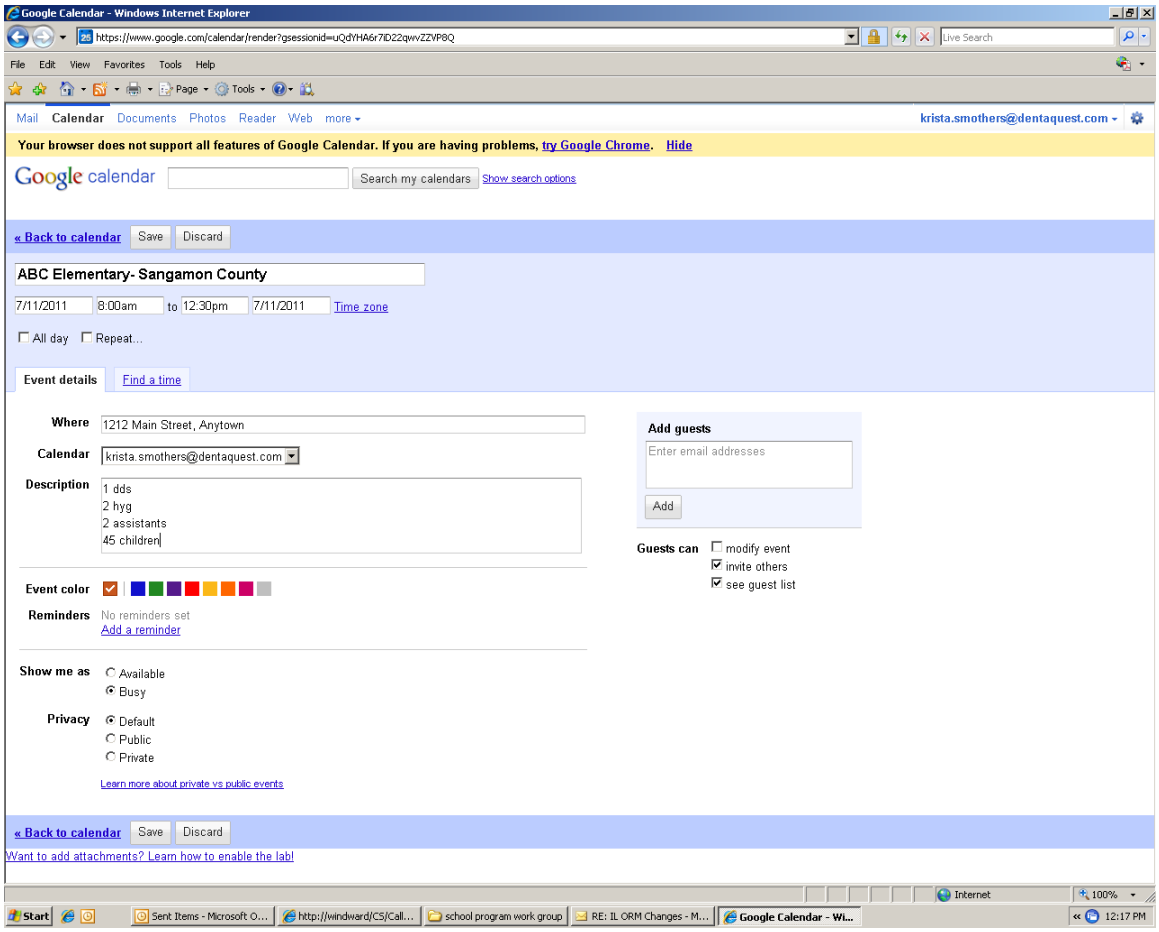
Instructions for Creating Google Calendar Account

1. Go to http://www.google.com/intl/en/googlecalendar/about.html in a Web browser
2. Click the 'Create an Account' button
3. Enter required information
   - Current email address
   - Choose password
   - Re-enter password
   - First name (this could be business name or manager of school program)
   - Last name (this could be business name or manager of school program)
   - Location
   - Time Zone
   - Birthday (use dummy birthday of 9/9/1970)
   - Word verification
4. Accept Terms of Service
5. Contact DentaQuest at 217.522.8906 or krista.smothers@dentaquest.com with username and password

Instructions for Using Google Calendar

1. Go to http://www.google.com/intl/en/googlecalendar/about.html in a Web browser
2. Click 'Sign in Now" button (on right)
3. Enter user name and password
4. Calendar will appear
5. Find date of scheduled school visit- double click on time Provider will be arriving
6. Box will appear-- enter school visit information
   - 'Title'- enter school name and county
   - 'Where'- enter school address including name of town
   - 'Description'- enter name of dentist/number of clinical staff to be present/ number of students to be seen
   - Leave other options as default
7. Click 'Save' (lower left)

Illinois All Kids School-Based Dental Program
Google Events Calendar



Attachment U
All Kids School-Based Dental Program
Provider Referral Plan

School-based dental Providers must develop a referral plan for follow-up care in the communities in which school-based services are rendered.

Please select the appropriate referral plan for each community in which school-based services are rendered.

Community_____ 20____ school year

_____ Children who receive services in the school-based dental program with an oral health score of 2 or 3 will be referred back to the school-based Provider's office to provide necessary follow up care and establish a Dental Home.

Office name: _____
Address: _____
Telephone number: _____

_____ Children who receive services in the school-based dental program with an oral health score of 2 or 3 will be provided necessary follow-up by the school-based Provider through the use of mobile restorative equipment. A yearly visit to the school by this Provider/entity will be scheduled to establish a continuation of care and case management as a mobile Dental Home.

_____ Children who receive services in the school-based dental program with an oral health score of 2 or 3 will be provided case management to follow-up care and provide referrals to the parent/guardian for necessary treatment. The case manager will locate a dental Provider who is willing to accept each child into their practice to perform required follow-up care and provide a Dental Home. Additionally, case management will include education to the parent/guardian regarding transportation benefits, when necessary.

Name of Case Manager: _____
Telephone number: _____

In dentistry, continuity of care is a critical component in ensuring a patient's oral health and well-being. The Dental Home promotes continuity of care by encouraging dental providers to manage the preventive, the diagnostic, and the restorative dental needs of their pediatric patients.

Attachment V
All Kids School-Based Dental Program
School Exam Follow-Up Care Form

Space for Logo

Date: ____/____/_____

Dear Parent or guardian of _____,
(student's name)

A dentist, Dr. _____, saw your child today.

The dentist gave your child:

___ Dental Exam
___ Cleaning
___ Fluoride
___ Dental sealants
(List Teeth)

Space for Referral Plan

This is what the dentist saw today. The picture shows where decay is. The other box shows more about your child's teeth and gums.

___ **1 – *No visual signs of decay***—See your dentist twice a year. Keep brushing and flossing every day. Please remember: This school oral health visit does not take the place of regular dental visits.
___ **2 – *Cavity/cavities***—Your child needs a check-up for fillings or crowns. Go to dentist **soon**.
___ **3 – *Dental disease***—Go to dentist **now**! Your child may have a toothache.

Your child has a cavity or cavities:

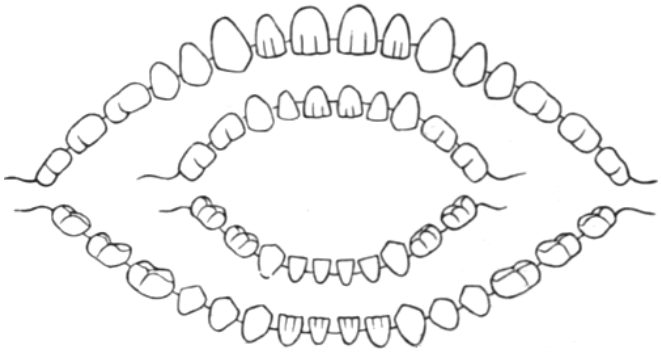
_____ No _____ Yes

Oral Hygiene (How **clean** the teeth are):

_____ Good _____ Fair _____ Poor

Periodontal Status (Health of **gums**):

_____ Good _____ Fair _____ Poor



Thank you for helping your child have healthy teeth and gums! Oral health is an important part of overall health. If you have any questions about your child's visit today, or would like to get dental records, please call _____ at (_____) _____ – _____ .

Address_____ License Number _____

Sincerely,

_____
(Dentist's signature)

_____
Phone Number

Notes:

Attachment V (Spanish)
All Kids School-Based Dental Program
School Exam Follow-Up Care Form

Space for Logo

Fecha: ____/____/_____

Estimado padre, madre o tutor de _____
Nombre del alumno)

Hoy, un dentista, el Dr. _____, examinó a su hijo(a).

El dentista le proporcionó:

___ Un examen dental
___ Una limpieza
___ Aplicación de fluoruro
___ Aplicación de selladores dentales
(en los siguientes dientes)
_____

Space for Referral Plan

Esto es lo que vio el dentista hoy. La ilustración muestra dónde hay caries. El otro cuadro muestra más información sobre los dientes y encías de su hijo(a).

___ **1 -** ***No No hay señales visibles de caries***—Vaya al dentista dos veces al año. Siga cepillándose y usando hilo dental todos los días. Recuerde: Esta consulta de salud bucodental en la escuela no sustituye el cuidado regular con un dentista.
___ **2 -** ***Una o más caries***—Su hijo(a) necesita ser examinado para obtener empastes o coronas. Vaya al dentista **pronto.**
___ **3 -** ***Enfermedad dental***—¡Vaya al dentista **ahora**! **Su hijo(a) podría tener dolor de dientes.**.

Su hijo(a) tiene una o más caries.

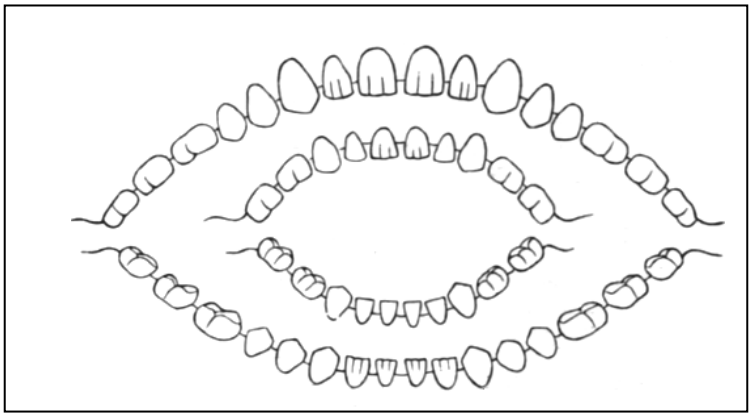
_____ _____
No Si

Higiene dental (cuán **limpios** están los dientes):

_____ _____ _____
Buena Regular Mala

Estado periodontal (salud de las **encías**):

_____ _____ _____
Buena Regular Mala



¡Gracias por ayudar a que su hijo(a) tenga dientes y encías sanos! La salud bucodental es parte importante de la salud general. Si tiene alguna pregunta sobre la consulta de su hijo(a) el día de hoy, o para obtener registros de historia dental, no dude en llamar a _____ al (_____) _____ – _____ .

Dirección_____ Número de licencia_____ .

Notas:

Atentamente,

_____
(Firma del dentista)

Illinois All Kids School-Based Dental Program
Referral Plan Language for the
School Exam Follow-Up Care Form

The box titled “Space for Referral Plan” on the School Exam Follow-Up Care Form provides a space for the School-Based Provider to indicate which type of Referral Plan will be used for each location.

Based on the Referral Plan chosen, use the following language:

Option 1: Please call to schedule an appointment with my office for follow-up care.

Name
Address
Phone Number

Option 2: [Insert your entity name] will be returning to this location on [insert date] to provide follow-up treatment. Please call [insert phone number] to schedule an appointment.

Option 3: The case manager for [Insert your entity name] will be contacting your for follow-up care information. If you don’t receive a call from us, please contact us at [insert phone number here].

Opción 1: Por favor, llame a mi oficina para programar una cita de cuidado de seguimiento.

Nombre
Dirección
Número de teléfono

Opción 2: [Inserte el nombre de su entidad] volverá a este local el [inserte fecha] para proveer tratamiento de seguimiento. Sírvase llamar al [inserte número de teléfono] para programar una cita.

Opción 3: El coordinador de caso de [Inserte el nombre de su entidad] se comunicará con usted para informarle del cuidado de seguimiento. Si no recibe una llamada nuestra, por favor comuníquese con nosotros al [inserte número de teléfono aquí].

Attachment W

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note_____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

Printed by Authority of the State of Illinois
P.O.#346085 5M 10/05

A copy of the IDPH Proof of School Dental Examination Form can be found on the IDPH Web site.

Attachment X
All Kids School-Based Dental Program
Instructions for Submission of School Event Data

*Oral Health Scores must be submitted within **30 days** of each event to hfs.dental@illinois.gov*

1. A Microsoft Excel electronic workbook will be provided to each entity upon approval in the All Kids School-Based Dental Program. The workbook is used to submit to HFS Beneficiaries' Oral Health Scores, the names of schools, and the numbers of children for whom services were provided. The workbook contains two separate spreadsheets, one labeled "Schools" and one labeled "Roster." (The spreadsheet tabs can be found at the bottom of the workbook screen; refer to the following page for a screen shot with an arrow pointing to the tabs.) Contact the HFS All Kids School-Based Dental Program Coordinator at 217/557-5438 to receive an electronic workbook. Do not add headings, additional rows or columns to the electronic form.

2. Data from multiple events may be combined into one workbook, as long as all of the data is received within 30 days of each event. It is possible to submit only one workbook per month, if it is submitted at the same time each month.

3. None of the fields should be left blank; all of the information is required.

4. The information on the two spreadsheets should correspond. That is, the events appearing on the "Schools" spreadsheet should be the exact events for which data is supplied on the "Roster" spreadsheet. The only difference would be that students who are not enrolled in All Kids would not need to be included on the "Roster" spreadsheet, but they would need to be counted on the "Schools" spreadsheet.

5. The names of all Microsoft Excel workbooks must include at least the following information:

   - The name of the dental entity/Provider. (The same name must be used consistently for all of the spreadsheets.)
   - The month(s) during which the range of event dates fall.

   Example:
   A spreadsheet for the School Provider "Terrific Teeth, Inc." for dates ranging from March 13, 2011 to April 13, 2011 should be named "Terrific Teeth, Inc. March, April 2011."

6. All Excel workbooks must be password protected for HIPAA compliance. The password will be provided with the instructions on password protection at the time each entity is approved in the All Kids School-Based Dental Program.

7. Contact the HFS All Kids School-Based Dental Program Coordinator at 217/557-5438 with questions regarding the password. **Do not send passwords for files containing Protected Health Information via e-mail.**

Sample "Roster" spreadsheet:

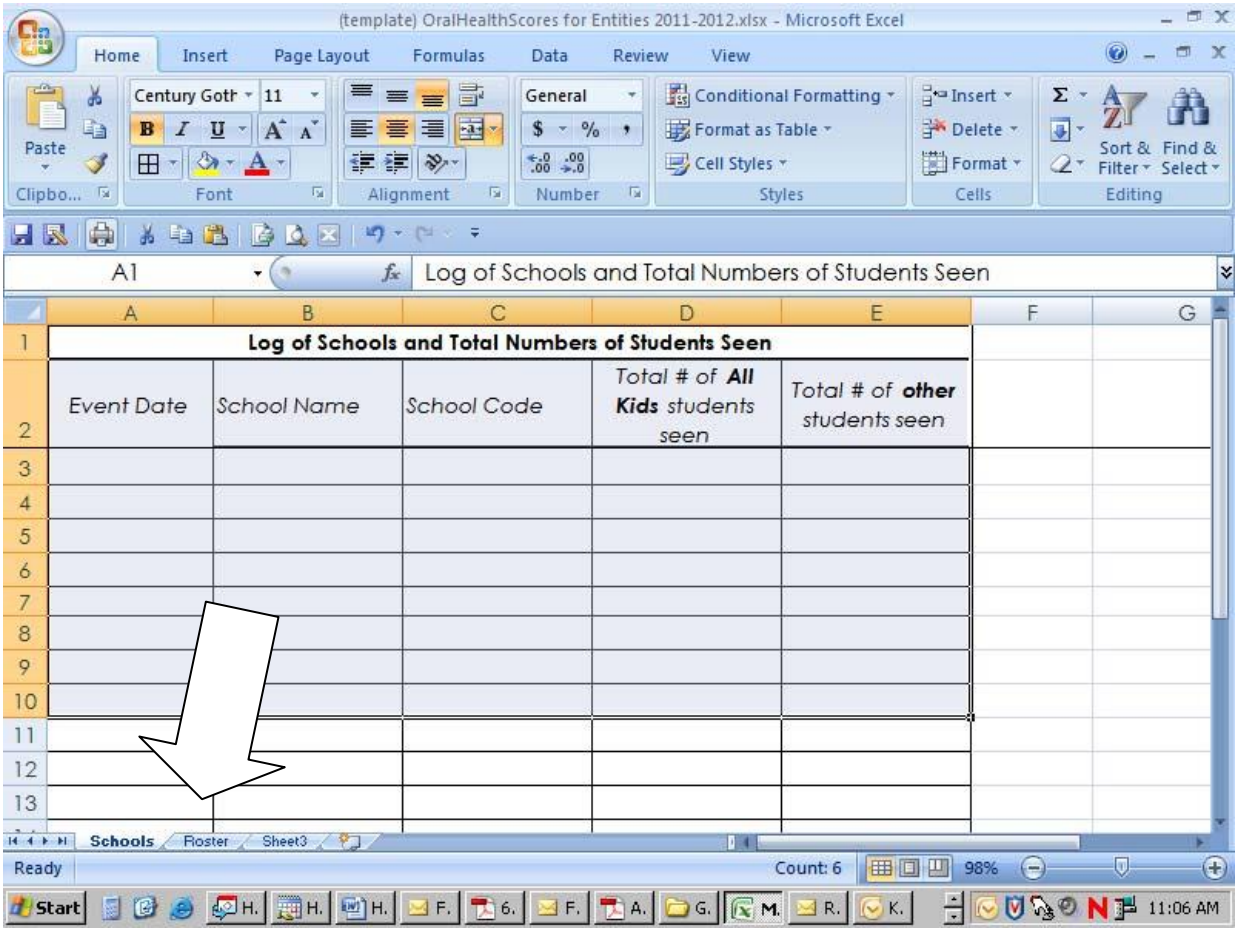
Last Name	First Name	RIN	Oral Health Score	Event Date	School
Doe	Jane	000000000	3	11/11/11	ABC Elementary
[Last Name]	[First Name]	000000000	2	"	"
[Last Name]	[First Name]	000000000	2	"	"

All Kids School-Based Dental Program
Instructions for Submission of School Event Data

Sample "Schools" spreadsheet:

Log of Schools and Total Numbers of Students Seen

Event Date	*School Name*	*School Code*	*Total # of **All Kids** students seen*	*Total # of **other** students seen*
8/1/2011	ABC Elementary	000000000000000 (15 digits)	25	5



Attachment Y
All Kids School-Based Dental Program
Sample Consent Form
Dental Exam
Must be returned tomorrow

Please print in ink:

Name Of School: _____
Teacher:_____ Grade:_____
County: _____

Dear Parent or Guardian,
(Name of entity) and the Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child to receive these services, **you must provide all the information requested below and sign in the area indicated.**

Your Childs Name:_____Birth Date: ___/___/___ Gender: M F

Address:_____City/Zip:_____Home Phone:( )____-_____
Does your child qualify for free or reduced meals: Yes No
Of Family Members: ____ Income Per Year (optional): _____
Is your child enrolled in the 'All Kids' Program: Yes No
If yes, Include you child's recipient ID number: ___ ___ ___ ___ ___
9 Digit Id Number On back of Medi-Plan card

Is your child covered by private dental insurance: Yes No
Name of Insurance Company_____
Insurance Telephone Number _____- _____Group Number _____
Employer Name _____
Name of Insured _____ Date of Birth _____
Social Security Number of Insured Person _____

Has your child had any history of, or conditions related to, any of the following:
____ Anemia ____ Chronic Sinusitis ___Growth problems ___ Seizures ____Asthma
____ Diabetes ____ Hearing ___Thyroid ____Bleeding disorders ____Ear aches
____ Heart ____Tobacco/ drug use ____ Cancer ____ Epilepsy ____ Latex allergy
____ Fainting ____ Cerebral Palsy ____Pregnancy (teens) Other_____
Is your child taking any prescription and/or over-the-counter medications at this time? Yes No
If yes, please list: _____
Does your child have any speech difficulties? Yes No
Has your child ever suffered injuries to the mouth, head, or teeth? Yes No
What type of water does your child drink? __City water __ Well water __Bottled water __ Filtered water

Important: Parent/guardian signature required
I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/ school representative and dental provider access to the child's dental record.

Signature: _____ **Date:** _____
In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA.
This will also give permission for IDPH, QA Audits to be performed and providers to return to your school to re-check your child's sealants.

Dentist's Initials _____

Attachment Z
All Kids School-Based Dental Program
Sample Dental Record

To Be Completed by Dentist

Treatment Received Today:

Exam _____
Fluoride treatment (gel) _____
Prophylaxis (including scaling, if needed) _____
Fluoride treatment (varnish) _____
Dental sealants (teeth #'s) _____

Current Dental Status Of Patient

Prior Treatment:	**Restorations**	**Sealants**
	_____	_____
	_____	_____
	_____	_____

Treatment Needed:	**Restorative**	**Sealants**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Oral Hygiene Status: ___ Good ___ Fair ___ Poor

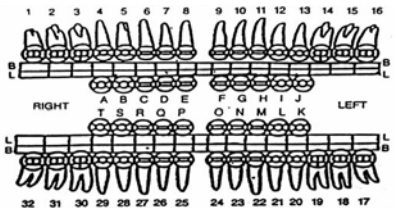
Periodontal Status: ___ Good ___ Fair ___ Poor

Oral Health Assessment Rating:

1. Preventive Care (services rendered today) - There is no visual evidence of caries activity or periodontal pathology.
2. Restorative Care- Amalgams, composites, crowns, etc.
3. Urgent Treatment- Abscess, nerve exposure advanced disease state, signs or symptoms that include pain, infection or swelling.

Oral Health Assessment Score: _____

Notes: _____
_____
_____



Dentist's Signature: _____ Treatment Date: _____

Attachment AA
Covered Services Comparison for Children and Adults

	Children (< age 21)	Adults (> age 20)	Requires Prior Approval
Diagnostic Services			
Oral Exams (For children, limited to one every 6 months per dentist in an office setting, and one every 12 months in a school setting. For adults, limited to 1st visit per dentist.)	X	X	
X-rays	X	X	
1 Preventive Services			
Prophylaxis – Cleanings (Once every 6 months)	X		
Topical Fluoride (Annual)	X		
Sealants	X		
Space Maintenance	X		
2 Restorative Services			
Amalgams	X	X	
Resins	X	X	
Crowns	X	X	Y
Sedative Fillings	X	X	
3 Endodontic Services			
Pulpotomy	X		
Root Canals (For adults, limited to facial front teeth only.)	X	X	
4 Periodontal Services			
Gingivectomy	X		Y
Scaling and Root Planing	X		Y
5 Removable Prosthodontic Services			
Complete Denture (upper and lower)	X	X	Y
Partial Denture (upper and lower)	X		Y
Denture Relines	X	X	Y
Maxillofacial Prosthetics	X	X	Y
6 Fixed Prosthetic Services			
Bridge	X		Y
7 Oral and Maxillofacial Services			
Extractions	X	X	
Surgical Extractions	X	X	Y
Alveoloplasty	X		Y
8 Orthodontic Services			
Orthodontia (Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting criteria for medical necessity)	X		Y
9 Adjunctive General Services			
General Anesthesia	X	X	Y
IV Sedation	X	X	Y
Nitrous Oxide	X	X	
Conscious Sedation	X	X	Y
Therapeutic Drug Injection	X	X	Y

Attachment BB
DentaQuest of Illinois, LLC

HFS Dental Program Fee Schedule for Children and Adult Beneficiaries
Rates Effective September 1, 2011
Please note: Adults have limited dental coverage. All services not covered are noted as N/A.

Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D0120	Periodic Oral Exam – Ages 0 thru 18	28.00	N/A
D0120	Periodic Oral Exam –Ages 19 thru 20	16.20	N/A
D0140	Limited Oral Examination – Problem Focused	16.20	16.20
D0150	Comprehensive Oral Examination	21.05	21.05
D0210	Intraoral-Complete Series (including bitewings)	30.10	30.10
D0220	Intraoral – periapical – first film	5.60	5.60
D0230	Intraoral periapical – 1 additional film	3.80	3.80
D0270	Bitewings Single Film	5.60	5.60
D0272	Bitewings-Two Films	9.40	9.40
D0274	Bitewings-Four Films	16.90	16.90
D0277	Vertical Bitewings – 7-8 Films	16.90	16.90
D0330	Panoramic Film	22.60	22.60
D1120	Prophylaxis - Child – Ages 0 thru 18	41.00	N/A
D1120	Prophylaxis - Child – Ages 19 thru 20	25.40	N/A
D1203	Topical Application of Fluoride (excluding prophy) – Ages 0 thru 18	26.00	N/A
D1203	Topical Application of Fluoride (excluding prophy) – Ages 19 thru 20	14.85	N/A
D1206	Topical Fluoride Varnish -Ages 0 thru 18	26.00	N/A
D1206	Topical Fluoride Varnish -Ages 19 thru 20	14.85	N/A
D1351	Sealant – Per Tooth	36.00	N/A
D1510	Space Maintainer - Fixed Unilateral	70.60	N/A
D1515	Space Maintainer - Fixed Bilateral	103.50	N/A
D1520	Space Maintainer – Removable Unilateral	70.60	N/A
D1525	Space Maintainer - Removable Bilateral	74.70	N/A
D1550	Space Maintainer – Recement	10.70	N/A
D2140	Amalgam-1-Surface, Primary or Permanent	30.85	30.85
D2150	Amalgam-2-Surfaces, Primary or Permanent	48.15	48.15
D2160	Amalgam-3-Surfaces, Primary or Permanent	58.05	58.05
D2161	Amalgam-4+-Surface, Primary or Permanent	58.05	58.05
D2330	Resin-Based Composite - 1-Surface, Anterior	34.60	34.60
D2331	Resin-Based Composite - 2-Surfaces, Anterior	51.90	51.90
D2332	Resin-Based Composite - 3-Surfaces, Anterior	61.80	61.80
D2335	Resin-Based Composite – 4+ surfaces, or involving Incisal Edge, Anterior	61.80	61.80
D2391	Resin-Based Composite – 1-surface, Primary or Permanent	30.85	30.85
D2392	Resin-Based Composite – 2-surfaces, Primary or Permanent	48.15	48.15
D2393	Resin-Based Composite – 3-surfaces, Primary or Permanent	58.05	58.05
D2394	Resin-Based Composite – 4+surfaces, Primary or Permanent	58.05	58.05
D2740	Crown – porc/ceramic	235.20	235.20
D2750	Crown – porc/metal high noble	235.20	235.20
D2751	Crown - Porcelain/Base Metal	235.20	235.20
D2752	Crown – porcelain/metal noble	235.20	235.20
D2790	Crown – full metal high noble	145.85	145.85
D2791	Crown - Full Cast Base Metal	145.85	145.85
D2792	Crown – full metal noble	145.85	145.85
D2910	Recement Inlays	11.30	11.30
D2915	Recement cast or prefabricated post and core	23.50	23.50

.

Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D2920	Recement Crown	23.50	23.50
D2930	Prefabricated Stainless Steel Crown (SSC) Primary Tooth	73.40	N/A
D2931	Prefabricated Stainless Steel Crown (SSC) Permanent Tooth	73.40	N/A
D2932	Prefabricated Resin Crown	56.45	56.45
D2933	Prefabricated Stainless Steel crown with resin window	56.45	N/A
D2934	Prefabricated esthetic coated stainless steel crown - primary	73.40	N/A
D2940	Protective Restorations	11.30	11.30
D2950	Core buildup, including any pins	58.05	58.05
D2951	Pin Retention-Per Tooth	9.40	9.40
D2954	Prefabricated Post and Core	32.90	32.90
D3220	Therapeutic Pulpotomy	52.70	N/A
D3222	Partial pulpotomy	28.20	N/A
D3230	Pulpal Therapy – (resorbable filling) – anterior, primary tooth (excl. final restoration)	52.70	N/A
D3310	Anterior Root Canal (Excluding Final Restoration)	136.40	136.40
D3320	Bicuspid Root Canal (Excluding Final Restoration)	155.25	N/A
D3330	Molar Root Canal (Excluding Final Restoration)	202.30	N/A
D3351	Apexification/Recalcification Initial Visit	28.20	N/A
D3352	Apexification/Recalcification Interim Visit	14.10	N/A
D3353	Apexification/Recalcification Final Visit	14.10	N/A
D3410	Apicoectomy/Periadicular Surgery — Per Tooth, First Root	112.90	N/A
D4210	Gingivectomy or Gingivoplasty — 4+ Teeth, Per Quadrant	131.70	N/A
D4211	Gingivectomy or Gingivoplasty — 1 to 3 Teeth, Per Quadrant	65.85	N/A
D4240	Gingival Flap Procedure, w/ Root Planing – 4+ Teeth, Per Quadrant	229.60	N/A
D4241	Gingival Flap Procedure, w/ Root Planing – 1 to 3 Teeth, Per Quadrant	114.80	N/A
D4260	Osseous Surgery – 4+ Teeth, Per Quadrant	277.60	N/A
D4261	Osseous Surgery – 1 to 3 Teeth, Per Quadrant	138.80	N/A
D4263	Bone Replacement Graft — First Site in Quadrant	141.15	N/A
D4264	Bone Replacement Graft, Each Additional Site in Quadrant	70.60	N/A
D4270	Pedicle Soft Tissue Graft	141.15	N/A
D4271	Free Soft Tissue Graft	141.15	N/A
D4273	Subepithelial Connective Tissue Graft Procedure	141.15	N/A
D4274	Distal or Proximal Wedge	70.60	N/A
D4320	Provisional Splinting, Intracoronal	188.20	N/A
D4321	Provisional Splinting, Extracoronal	56.50	N/A
D4341	Periodontal Scaling and Root Planing – 4+ Teeth, Per Quadrant	122.00	N/A
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth, Per Quadrant	77.00	N/A
D4355	Full mouth Debridement	41.00	N/A
D4910	Periodontal Maintenance Procedure	67.00	N/A
D5110	Complete Denture - Maxillary	376.35	376.35
D5120	Complete Denture - Mandibular	376.35	376.35
D5130	Immediate Denture – Maxillary	376.35	376.35
D5140	Immediate Denture – Mandibular	376.35	376.35
D5211	Maxillary Partial Denture — Resin Base	357.55	N/A
D5212	Mandibular Partial Denture — Resin Base	357.55	N/A
D5213	Maxillary Partial Denture — Cast Metal Framework	366.95	N/A
D5214	Mandibular Partial Denture — Cast Metal Framework	366.95	N/A
D5510	Repair Complete Denture Base	61.15	61.15
D5520	Replace Missing or Broken Teeth, Complete Denture	38.10	38.10
D5610	Repair Partial Denture Base	51.75	51.75
D5620	Repair Cast Framework	79.05	79.05
D5630	Repair or Replace Broken Clasp	71.50	71.50
D5640	Replace Broken Teeth, Each Additional Tooth	37.65	37.65

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D5650	Add Tooth to Existing Partial	42.35	42.35
D5730	Reline Complete Maxillary Denture, Chairside	70.60	70.60
D5731	Reline Complete Mandibular Denture, Chairside	70.60	70.60
D5740	Reline Maxillary Partial Denture, Chairside	70.60	70.60
D5741	Reline Mandibular Partial Denture, Chairside	70.60	70.60
D5750	Reline Complete Maxillary Denture, Laboratory	117.60	117.60
D5751	Reline Complete Mandibular Denture, Laboratory	117.60	117.60
D5760	Reline Maxillary Partial Denture, Laboratory	117.60	117.60
D5761	Reline Mandibular Partial Denture, Laboratory	117.60	117.60
D5911	Facial Moulage-sectional	By Report	By Report
D5912	Facial Moulage-complete	By Report	By Report
D5913	Nasal Prosthesis	By Report	By Report
D5914	Auricular Prosthesis	By Report	By Report
D5915	Orbital Prosthesis	By Report	By Report
D5916	Ocular Prosthesis	By Report	By Report
D5919	Facial Prosthesis	By Report	By Report
D5922	Nasal Septal Prosthesis	By Report	By Report
D5923	Ocular Prosthesis, interim	By Report	By Report
D5924	Cranial Prosthesis	By Report	By Report
D5925	Facial Augmentation implant Prosthesis	By Report	By Report
D5926	Nasal Prosthesis, replacement	By Report	By Report
D5927	Auricular Prosthesis, replacement	By Report	By Report
D5928	Orbital Prosthesis, replacement	By Report	By Report
D5929	Facial Prosthesis, replacement	By Report	By Report
D5931	Obturator Prosthesis, surgical	By Report	By Report
D5932	Obturator Prosthesis, definitive	By Report	By Report
D5933	Obturator Prosthesis, modification	By Report	By Report
D5934	Mandibular Resection Prosthesis with guide flanges	By Report	By Report
D5935	Mandibular Resection Prosthesis without guide flanges	By Report	By Report
D5936	Obturator Prosthesis, interim	By Report	By Report
D5937	Trismus Appliance	By Report	By Report
D5951	Feeding Aid	By Report	By Report
D5952	Speech Aid Prosthesis, pediatric	By Report	N/A
D5953	Speech Aid Prosthesis, adult	By Report	By Report
D5954	Palatal Augmentation, Prosthesis	By Report	By Report
D5955	Palatal Lift Prosthesis, definitive	By Report	By Report
D5958	Palatal Lift Prosthesis, Interim	By Report	By Report
D5959	Palatal Lift Prosthesis, modification	By Report	By Report
D5960	Speech Aid Prosthesis, modification	By Report	By Report
D5982	Surgical Stent	By Report	By Report
D5983	Radiation Carrier	By Report	By Report
D5984	Radiation Shield	By Report	By Report
D5985	Radiation Cone Locator	By Report	By Report
D5986	Fluoride Gel Carrier	By Report	By Report
D5987	Commissure Splint	By Report	By Report
D5988	Surgical Splint	By Report	By Report
D5999	Unspecified Maxillofacial Prosthesis	By Report	By Report
D6210	Pontic crown – metal high noble	178.80	N/A
D6211	Pontic crown – metal base	178.80	N/A
D6212	Pontic crown – metal noble	178.80	N/A
D6240	Pontic crown – porc/metal high noble	178.80	N/A
D6241	Pontic crown - porc/base Metal	178.80	N/A
D6242	Pontic crown – porc metal noble	178.80	N/A
D6251	Pontic-Resin/Base Metal	103.50	N/A

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D6721	Crown-Resin/Predominately Base Metal	136.40	N/A
D6750	Crown – porc/metal high noble	159.95	N/A
D6751	Crown-Porcelain/Predominately Base Metal	159.95	N/A
D6752	Crown – porc/metal noble	159.95	N/A
D6790	Crown – full metal high noble	159.95	N/A
D6791	Crown - full metal base	159.95	N/A
D6792	Crown - full metal noble	159.95	N/A
D6930	Recement Fixed Partial Denture	32.90	32.90
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	26.35	N/A
D6999	Unspecified, fixed prosthodontic procedure, by report	By Report	By Report
D7140	Extraction – Erupted Tooth or Exposed Root	39.12	39.12
D7210	Surgical Removal of Erupted Tooth	57.40	57.40
D7220	Removal of Impacted Tooth — Soft Tissue	66.80	66.80
D7230	Removal for Impacted Tooth — Partially Bony	86.60	86.60
D7240	Removal of Impacted Tooth — Completely Bony	100.70	100.70
D7250	Surgical Removal of Residual Roots	57.40	57.40
D7270	Tooth reimplantation and/ or stabilization	88.00	N/A
D7280	Surgical access of unerupted tooth	50.80	N/A
D7283	Placement of device to facilitate eruption of impacted tooth	45.00	N/A
D7310	Alveoloplasty in Conjunction with Extractions — per quadrant	64.00	64.00
D7311	Alveoloplasty w/ extraction – 1-3 teeth/spaces per quad	64.00	64.00
D7320	Alveoloplasty Not in Conjunction With Extractions — per quadrant	64.00	64.00
D7321	Alveoloplasty w/o extractions – 1- 3 teeth/spaces per quad	64.00	64.00
D7450	Removal of Odontogenic Cyst or Tumor up to 1.25cm	94.30	94.30
D7451	Removal of Odontogenic Cyst orTumor over 1.25cm	199.60	199.60
D7460	Removal of Non-Odontogenic Cyst or Tumor up to 1.25cm	94.30	94.30
D7461	Removal of Non-Odontogenic Cyst or Tumor over 1.25cm	199.60	199.60
D7510	Incision and Drainage – Abscess	36.70	36.70
D7511	Incision & drainage – intraoral - complicated	36.70	36.70
D7610	Maxilla Open Reduction, Teeth Immobilized	657.95	657.95
D7620	Maxilla Closed Reduction, Teeth Immobilized	471.50	471.50
D7630	Mandible-Open Reduction, Teeth Immobilized	824.65	824.65
D7640	Mandible-Closed Reduction, Teeth Immobilized	706.95	706.95
D7710	Maxilla-Open Reduction	1059.35	1059.35
D7720	Maxilla-Closed Reduction	706.35	706.35
D7730	Mandible-Open Reduction	1059.35	1059.35
D7740	Mandible-Closed Reduction	706.20	706.20
D7810	Open Reduction of Dislocation	438.60	438.60
D7820	Closed Reduction of Dislocation	177.65	177.65
D7960	Frenulectomy-Separate Procedure (frenectomy or frenotomy)	77.15	N/A
D7963	Frenuloplasty	77.15	N/A
D7999	Unspecified Oral Surgery Procedure	By Report	By Report
D8080	Initial Orthodontic Appliance Placement	900.00	N/A
D8660	Initial Examination, Records, Radiographs & Facial Photographs	100.00	N/A
D8670	Periodic Adjustments (11 maximum)	240.00	N/A
D8680	Removal of Appliances, Construction, and Placement of Retainers	150.00	N/A
D8999	Initial Orthodontic Evaluation/Study Models	47.05	N/A
D9110	Palliative (emergency) Treatment of Dental Pain-Minor Procedures	55.00	55.00
D9220	General Anesthesia – Require Dental Sedation Permit B to bill	76.70	76.70
D9221	General Anesthesia – each additional 15 minutes	38.35	38.35
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia	26.00	26.00
D9241	Intravenous Sedation – Require Dental Sedation Permit A to bill	76.70	76.70
D9242	Intravenous Sedation – Each additional 15 minutes	38.35	38.35

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D9248	Non-intravenous conscious sedation – Require Dental Sedation Permit A to bill	48.00	48.00
D9310	Consultation	17.10	17.10
D9610	Therapeutic Drug Injection	By Report	By Report
D9630	Other Drugs and Medicaments	23.50	23.50
D9999	Unspecified Procedure, By Report	By Report	By Report

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Attachment CC

HFS Dental Program/All Kids Program
Dental Visit Co-Payments

	All Kids Previously called Kid Care			Expanded Coverage Under All Kids/HFS Dental Program						
Dental Visit Types	**All Kids Assist**	**All Kids Share**	**All Kids Premium Level 1**	**All Kids Premium Level 2**	**All Kids Premium Level 3**	**All Kids Premium Level 4**	**All Kids Premium Level 5**	**All Kids Premium Level 6**	**All Kids Premium Level 7**	**All Kids Premium Level 8**
Preventive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Diagnostic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Restorative	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Endodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Peridontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Prosthodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Oral and Maxillofacial Surgery	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Orthodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Adjunctive Services	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25

All Kids Premium Levels 3-8 are available to current enrolled members only until June 30, 2012. Beginning July 1, 2012 All Kids Premium Levels 3-8 will no longer be available.

Attachment DD

Illinois Department of Healthcare and Family Services

Dental Periodicity Schedule

(Effective July 1, 2011)

The Illinois Department of HealthCare and Family Services (HFS) Dental Health Periodicity Schedule has utilized the American Academy of Pediatric Dentistry Periodicity Schedule oral health recommendations as a guide, and has consulted with the medical and dental communities. This schedule is designed for the care of children who have no contributing medical conditions and should be modified for children with special health care needs or in the event of trauma or disease results in variations from the norm.

As part of the well child visit, the Primary Care Provider (PCP) (medical home) performs an oral health screening, with recommendations from HFS to follow the American Academy of Pediatrics guidelines, and as detailed in the guidance provided by the HFS Handbook for Providers of Healthy Kids Services in accordance with Bright Futures. An oral screening is part of the well child physical examination but does not replace referral to a dentist. Children should receive an oral health risk screening from their PCP by six months of age that includes: (1) assessing the child's risk factors for developing oral disease; providing education on the importance of oral health; and evaluating and optimizing fluoride exposure. Anticipatory guidance related to oral health provided to the parent, guardian and child should be age appropriate and follow the Bright Futures in Practice: ORAL HEALTH Pocket Guide.

At age two, or earlier as needed, children are to be referred to a dentist for routine and periodic preventive dental care. For children under age two, the oral health screening performed by the PCP is to identify children who require evaluation by a dentist, and to provide evidence based/informed preventive oral health services, including anticipatory guidance.

Illinois Department of HealthCare and Family Services
Dental Periodicity Schedule
Birth to Age 21

SERVICE	Birth – 12 Months	12-24 Months	24 Months to 3 years	3-6 Years	6-12 Years	12 Years & Older
Anticipatory Guidance/Counseling[1]	•	•	•	•	●	●
Oral Health Screening by PCP (at physical exam)	•	•	•	•	●	●
Clinical Oral Examination[2]			•	•	●	●
Assess oral growth and development[3]	•	•	•	•	●	●
Caries-risk assessment 3	•	•	•	•	●	●
Fluoride Supplementation/ Topical Fluoride Varnish	•	•	•	•	●	●
Referral to a Dental Home by the PCP[4]			•	•	●	●
Radiographic Assessment			•	•	●	●
Pit & Fissure Sealants[5]				●	●	●
Fluoride Supplementation/ Topical Fluoride Varnish	●	●	●	●	●	●
Assessment and possible removal of 3rd molars						●

Note: While some services are not noted in a certain age category (e.g., birth to 12 months), those services are available, as medically necessary, to those children.

[1] Appropriate discussion and counseling is a part of each visit for care and includes age appropriate topics, such as oral hygiene, including brushing and flossing; fluoride, diet and nutrition; early childhood caries prevention; injury prevention; speech/language development; piercing; substance abuse (e.g., smoking).
[2] Every six months in an office setting. Includes assessment of pathology and injuries.
[3] Occurs at the PCP and Dentist visits.
[4] Referral to a dentist is recommended routinely by age 2, or earlier as medically necessary.
[5] For caries susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Exhibit A Benefits Covered for
Children under the Age of 21

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health. For children entering or in kindergarten, second grade, and sixth grade, completion of a mandated IDPH Proof of School Dental Examination form is considered part of the oral examination. Providers must complete the exam form free of charge if requested by the parent or guardian within six (6) months of the oral examination.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for 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 policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment M of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

An initial examination is typically used when evaluating a patient comprehensively (D0150). It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic examination (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) examination (D0150 or D0120) is used when evaluating a child comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

Place of service must be indicated on all claims.

Out-of-office services: Providers who render preventive exams in an out-of-office setting must check the "Other" box on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the "Provider's Office" or "ECF" (Extended Care Facility) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate.

Dental Providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleanings and fluoride treatment. Each provider must provide any follow-up sealants in addition to the exam, cleaning and fluoride treatment when needed.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation	0-20		No	One of (D0120) per 6 Month(s) Per patient. Participants are also eligible for one periodic oral evaluation (D0120) performed in school setting per 12 months. Completion of a mandated school exam form is considered part of the oral examination.	
D0140	limited oral evaluation-problem focused	0-20		No	One of (D9110) per 1 Day(s) Per Provider OR Location. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with D9110.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0210	intraoral-complete series (including bitewings)	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	0-20		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral-periapical-each additional film	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single film	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two films	2 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four films	10 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

Exhibit A Benefits Covered for Children under the Age of 21

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic film	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

Exhibit A Benefits Covered for Children under the Age of 21

Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy for Participants age 0 through 20. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once every 6 months. Prophylaxis includes necessary scaling and polishing.

Fluoride treatment (D1203 or D1206) is allowed once every 12 months in an office setting for Participants age 3 through 20. Fluoride treatment (D1203 or D1206) is allowed once every 12 months in a school setting for Participants age 3 through 20.

For ages 0 to 2, three fluoride varnish treatments (D1206) are allowed per patient per 12 months in an office setting.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

Space maintainers are a covered service for Participants age 1 through 20 when determined by the dentist to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

Place of service must be indicated on all claims.

Out-of-office services: Providers who render preventive services in an out-of-office setting must check the “Other” box on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the “Provider’s Office” or “ECF” (Extended Care Facilities) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate.

Dental providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning and fluoride treatment. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed.

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1120	prophylaxis - child	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office setting. One of (D1120) per 6 months in a school setting. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	
D1203	topical application of fluoride (prophylaxis not included) - child	0-20		No	One of (D1203, D1206) per 12 Month(s) Per patient. in an office setting. One of (D1203 or D1206) per 12 months per patient in a school setting. (Both codes, D1203/D1206 are NOT permitted in the same 12 months w/in the same treatment setting.)	
D1206	topical flouride varnish	0-20		No	One of (D1203, D1206) per 12 Month(s) Per patient. Three of (D1203, D1206) per 12 Month(s) Per patient. Ages 0 - 2 - Three per 12 months per patient in an office setting. Ages 3 - 20 - One of (D1203 or D1206) per 12 Month(s) Per patient in an office setting. One of (D1203 or D1206) per 12 Month(s) Per patient in a school setting. (Both codes, D1203/D1206 are NOT permitted in the same 12 months w/in the same treatment setting.) Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 1 Lifetime Per patient per tooth. per tooth, regardless of place of service. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Provider OR Location per quadrant. Per arch or quadrant, per appliance.	
D1515	space maint-fixed-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515) per 1 Lifetime Per Provider OR Location per arch. Per arch or quadrant, per appliance.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Provider OR Location per quadrant. Per arch or quadrant, per appliance.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1525) per 1 Lifetime Per Provider OR Location per arch. Per arch or quadrant, per appliance.	
D1550	recementation space maintainer	0-20		No		

Exhibit A Benefits Covered for Children under the Age of 21

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. 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.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2160	Amalgam - three surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2161	Amalgam - four surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2330	resin-1 surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2331	resin-2 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2332	resin-3 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	

Exhibit A Benefits Covered for Children under the Age of 21

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - 1 surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2392	resin-based composite - 2 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2393	resin-based composite - 3 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2394	resin-based composite - 4 or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2740	crown-porcelain/ceramic substrate	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown-porcelain fused to high noble	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown-porcelain fused to metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown-porcelain fused noble metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown-full cast high noble	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast base metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	recement inlay	0-20	Teeth 1 - 32	No		

Exhibit A Benefits Covered for Children under the Age of 21

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2915	recement cast or prefabricated post and core	0-20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	recement crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2933	prefabricated steel crown with resin window	0-20	Teeth C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 not covered services).	
D2950	core buildup, including any pins	0-20	Teeth 1 - 32	No		
D2951	pin retention - per tooth in addition to restoration	0-20	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes		Final fill periapical x-ray

Exhibit A Benefits Covered for
Children under the Age of 21

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Dental Industry (or ADA) 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.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration)	0-20	Teeth A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3222	partial pulpotomy for apexogenesis	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3222, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3222 covered for trauma cases only	narr. of med. necessity, pre-op x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth	0-20	Teeth C - H, M - R	No		
D3310	Endodontic therapy, anterior (exc final rest)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3320	Endodontic therapy, bicuspid (exc final restore)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3330	Endodontic therapy, molar(excluding final restore)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	

Exhibit A Benefits Covered for Children under the Age of 21

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3351	apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3351) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3352	apexification/recalcification/pulpal regeneration – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3353) per 1 Lifetime Per patient per tooth.	Pre and post-operative x-ray(s)
D3410	apicoectomy/periradicular surgery - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Not payable concurrently with root canal treatment of tooth.	pre-operative x-ray(s)

Exhibit A Benefits Covered for Children under the Age of 21

Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty, per tooth	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing - 1-3 teeth, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including flap entry and closure) - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including flap entry and closure) - 1-3 teeth, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Provider OR Location per quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft-1st quadrant site	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4271	free soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting

Exhibit A Benefits Covered for Children under the Age of 21

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4320	provision splinting - intracoronal	0-20	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4321	provision splinting - extracoronal	0-20	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - 1-3 teeth, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable comprehensive periodontal evaluation	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office setting.	
D4910	periodontal maintenance procedures	0-20		Yes	Only covered after active therapy has been performed.	pre-op x-ray(s), perio charting

Exhibit A Benefits Covered for
Children under the Age of 21

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. The date of placement must be used as the date of service when submitting for payment of dentures. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	0-20		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	0-20		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	0-20		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5211	maxillary partial denture-resin base	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5212	mandibular partial denture-resin base	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5213	maxillary part denture - cast metal framework with resin bases	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5214	mandibular partial denture - cast metal framework with resin bases	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5510	repair broken complete denture base	0-20	Per Arch (01, 02, LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5610	repair resin denture base	0-20	Per Arch (01, 02, LA, UA)	No		
D5620	repair cast framework	0-20	Per Arch (01, 02, LA, UA)	No		
D5630	repair or replace broken clasp	0-20		No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chair)	0-20		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chair)	0-20		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture(chair)	0-20		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chair)	0-20		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	0-20		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	0-20		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement

Exhibit A Benefits Covered for Children under the Age of 21

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5760	reline maxillary partial denture (laboratory)	0-20		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	0-20		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement

Exhibit A Benefits Covered for Children under the Age of 21

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5911	facial moulage (sectional)	0-20		Yes		narrative of medical necessity
D5912	facial moulage (complete)	0-20		Yes		narrative of medical necessity
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5914	auricular prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5919	facial prosthesis	0-20		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	0-20		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	0-20		Yes		narrative of medical necessity
D5924	cranial prosthesis	0-20		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	0-20		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	0-20		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	0-20		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity

Exhibit A Benefits Covered for Children under the Age of 21

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5933	obturator prosthesis, modification	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	0-20		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	0-20		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	0-20		Yes		narrative of medical necessity
D5952	speech aid prosthesis, pediatric	0-12		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	13-20		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	0-20		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	0-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes		narrative of medical necessity
D5982	surgical stent	0-20		Yes		narrative of medical necessity
D5983	radiation carrier	0-20		Yes		narrative of medical necessity
D5984	radiation shield	0-20		Yes		narrative of medical necessity
D5985	radiation cone locator	0-20		Yes		narrative of medical necessity

Exhibit A Benefits Covered for Children under the Age of 21

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5986	fluoride gel carrier	0-20		Yes		narrative of medical necessity
D5987	commissure splint	0-20		Yes		narrative of medical necessity
D5988	surgical splint	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6211	pontic-cast base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6212	pontic - cast noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6240	pontic-porcelain fused-high noble	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6241	pontic-porcelain fused metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)

Exhibit A Benefits Covered for Children under the Age of 21

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6251	pontic-resin with base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6721	crown-resin with base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6750	crown-porcelain fused high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6751	crown-porcelain fused to metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6752	crown-porcelain fused noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6790	crown-full cast high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6791	crown - full cast base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6792	crown - full cast noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6930	recement fixed partial denture	0-20	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	

Exhibit A Benefits Covered for Children under the Age of 21

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6972	prefabricated post and core + retainer	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	Final fill periapical x-ray
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

Exhibit A Benefits Covered for Children under the Age of 21

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9220 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction - erupted or exposed root	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

Exhibit A Benefits Covered for Children under the Age of 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review.	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons.	pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	pre-operative x-ray(s)
D7310	alveoloplasty in conjunction with extractions per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report

Exhibit A Benefits Covered for Children under the Age of 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	0-20		Yes	One of (D7960, D7963) per 1 Lifetime Per patient. One per arch per lifetime.	narr. of med. necessity, model or photo
D7963	frenuloplasty	0-20		Yes	One of (D7960, D7963) per 1 Lifetime Per patient. One per arch per lifetime.	Narrative of medical necessity and photos

Exhibit A Benefits Covered for Children under the Age of 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7999	unspecified oral surgery procedure, by report	0-20		Yes		narrative of medical necessity

Exhibit A Benefits Covered for
Children under the Age of 21

Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. Participants must have a severe, dysfunctional, hadicapping malocclusion as determined by a score of 42 points or greater on the modified salzmann index, or objective documentation that the malocclusion is an impairment of, or a hazard to the ability to eat, chew, speak, or breathe. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1.800.322.3722.

Criteria for Orthodontia Services

Documentation

Previously DentaQuest required plaster models, in addition to other required documentation such as x-rays, to review the necessity of the request for orthodontic treatment. DentaQuest now accepts a complete series of intra-oral photos instead of the plaster models. All other required documentation, including panoramic and cepholometric films, tracings, score sheets, and narratives; must be submitted with the photos. This change was made to reduce postage costs for provider; increase the speed with which records are returned, and eliminate the possibility of models being damaged in shipment. If your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:

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

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements. All other currently required documentation, including panoramic and cepholometric x-rays, tracings, narratives, and scoring forms will continue to be required for review.

If your office currently submits digital models through OrthoCad these are still accepted and no change needs to be made regarding the submission of models.

In addition to the photographs, plaster models or digital models, authorization for orthodontia services requires a claim form listing the requested services, the Orthodontic Criteria Index Form (Attachment G), and any other documentation that supports medical necessity.

Criteria

•All comprehensive orthodontic services require prior authorization by one of DentaQuest's Dental Consultants.

•An Orthodontia patient should present with a full erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.
•As of July 1, 2010, HFS Dental Program Beneficiaries are evaluated for orthodontia coverage using medical necessity/handicapping criteria as the first level review (Attachment G). If the requested orthodontia treatment meets one of the listed criteria, DentaQuest approves the request as meeting medically necessary handicapping criteria.
•If the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form (Attachment G), DentaQuest will proceed with evaluating the request by applying the Salzmann Malocclusion Severity Assessment (Attachment H).
•A patient must score a 42 or higher to qualify for orthodontia services using the Salzmann Malocclusion Severity Assessment, if the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form.

Billing

The charge for intial exam, radiographs and study models for approved cases should be submitted under procedure code D8660. The charges for these services for cases that do not meet the criteria should be submitted using code D8999.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). In order to receive reimbursement for orthodontic adjustments, provider must bill for each date of service treatment was rendered. Only one D8670 allowed per 45 days and 11 D8670's allowed per case per lifetime. If a Participant fails to keep an appointment for two consecutive appointments, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled as follows:

1. For cases that were started prior to the date the Participant was enrolled in the HFS Dental Program, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Dental Consultant. The Modified Salzmann Index will be performed and the original records reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a proration of the remaining treatment will be authorized.

2. For cases that were started under the HFS Dental Program, a Participant will be allowed to transfer treatment only under extreme situations. Usually this will be limited to when a Participant moves out of the immediate service area. In this instance, the dentist who will complete the treatment must submit a claim form indicating the treatment status of the case, his/her intention to continue care and a charge for the remaining treatment. DentaQuest will review the request on a case by case basis and issue a determination of benefits.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment visit	0-20		Yes	One of (D8660) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays

Exhibit A Benefits Covered for Children under the Age of 21

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit (as part of contract)	0-20		Yes	One of (D8670) per 45 Day(s) Per patient. Maximum of 1 per 45 days regardless of number of visits within 45 day period.	
D8680	orthodontic retention (removal of appliances)	0-20		Yes	One of (D8680) per 1 Lifetime Per patient.	Date of de-banding with claim form
D8999	unspecified orthodontic procedure, by report	0-20		Yes	One of (D8999) per 1 Lifetime Per patient. Only covered if case fails to reach 42 points on the Modified Salzman Index.	narrative of medical necessity

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9241, D9242, and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure codes D9220 and D9221 require a dental sedation permit B in order to perform service.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	One of (D0140) per 1 Day(s) Per Provider OR Location. Not covered with D0140 on same date of service.	
D9220	general anesthesia - first 30 minutes	0-20		Yes	Permit B is required. Not allowed on the same date of service as D9230, D9241, D9242, or D9248.	narrative of medical necessity
D9221	general anesthesia - each additional 15 minutes	0-20		Yes	Four of (D9221) per 1 Day(s) Per Provider OR Location. Not allowed on the same date of service with D9230, D9241, D9242 or D9248. Permit B is required.	narrative of medical necessity
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	0-20		No	Not allowed on the same date of service as D9220, D9221, D9241, D9242, or D9248.	narrative of medical necessity
D9241	intravenous sedation/analgesia - first 30 minutes	0-20		Yes	Permit A or B is required. Not allowed on same date of service as D9220, D9221, D9230, or D9248.	narrative of medical necessity
D9242	intravenous sedation/analgesia - each additional 15 minutes	0-20		Yes	Four of (D9242) per 1 Day(s) Per Provider OR Location. Not allowed on the same date of service with D9220, D9221, D9230, or D9248. Permit A or B is required.	narrative of medical necessity
D9248	non-intravenous conscious sedation	0-20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9220, D9221, D9230, D9241, or D9242.	narrative of medical necessity
D9310	consultation	0-20		No		narrative of medical necessity
D9610	therapeutic drug injection, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	0-20		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

Exhibit B Benefits Covered for Adults – Age 21 and Older

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 Participant's oral health. Periodic exams are not a covered benefit for Participants age 21 and over.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for 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 policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment M of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

An initial examination is typically used when evaluating a patient comprehensively (D0150). It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Place of service must be indicated on all claims.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	21 and older		No	Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with D9110.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation	21 and older		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0210	intraoral-complete series (including bitewings)	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral-periapical-each additional film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

Exhibit B Benefits Covered for Adults – Age 21 and Older

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two films	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four films	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Provider OR Location. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic film	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

Exhibit B Benefits Covered for Adults – Age 21 and Older

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. 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.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2160	Amalgam - three surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2161	Amalgam - four surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2330	resin-1 surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2331	resin-2 surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2332	resin-3 surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	

Exhibit B Benefits Covered for Adults – Age 21 and Older

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-4+ surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2391	resin-based composite - 1 surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2392	resin-based composite - 2 surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2393	resin-based composite - 3 surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2394	resin-based composite - 4 or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2740	crown-porcelain/ceramic substrate	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)
D2750	crown-porcelain fused to high noble	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)
D2751	crown-porcelain fused to metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown-porcelain fused noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)
D2790	crown-full cast high noble	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)
D2791	crown - full cast base metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)

Exhibit B Benefits Covered for Adults – Age 21 and Older

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Per Tooth.	pre-operative x-ray(s)
D2910	recement inlay	21 and older	Teeth 1 - 32	No		
D2915	recement cast or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	recement crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or Provider group.	
D2931	prefabricated steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 not covered services).	
D2950	core buildup, including any pins	21 and older	Teeth 1 - 32	No		
D2951	pin retention - per tooth in addition to restoration	21 and older	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes		Final fill periapical x-ray

Exhibit B Benefits Covered for
Adults – Age 21 and Older

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet dental industry or ADA 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.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3310	Endodontic therapy, anterior (exc final rest)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3310 is the only RCT code covered for members over 21. If one of the following codes (D3320, D3330, D3351,D3352, D3353) was previously paid for the member as part of under 21 benefit the service D3310 is not payable.	

Exhibit B Benefits Covered for
Adults – Age 21 and Older

Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. The date of placement must be used as the date of service when submitting for payment of dentures. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5510	repair broken complete denture base	21 and older	Per Arch (LA, UA)	No		

Exhibit B Benefits Covered for Adults – Age 21 and Older

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5610	repair resin denture base	21 and older	Per Arch (01, 02, LA, UA)	No		
D5620	repair cast framework	21 and older	Per Arch (01, 02, LA, UA)	No		
D5630	repair or replace broken clasp	21 and older		No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chair)	21 and older		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chair)	21 and older		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture(chair)	21 and older		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chair)	21 and older		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5120, D5731, D5741, D5751, D5761) per 24 Month(s) Per patient.	Date of denture placement

Exhibit B Benefits Covered for Adults – Age 21 and Older

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5911	facial moulage (sectional)	21 and older		Yes		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		Yes		narrative of medical necessity
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5914	auricular prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5924	cranial prosthesis	21 and older		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity

Exhibit B Benefits Covered for Adults – Age 21 and Older

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5933	obturator prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	21 and older		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narrative of medical necessity
D5983	radiation carrier	21 and older		Yes		narrative of medical necessity
D5984	radiation shield	21 and older		Yes		narrative of medical necessity
D5985	radiation cone locator	21 and older		Yes		narrative of medical necessity
D5986	fluoride gel carrier	21 and older		Yes		narrative of medical necessity

Exhibit B Benefits Covered for Adults – Age 21 and Older

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5987	commissure splint	21 and older		Yes		narrative of medical necessity
D5988	surgical splint	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity

Exhibit B Benefits Covered for Adults – Age 21 and Older

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6930	recement fixed partial denture	21 and older		No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for
Adults – Age 21 and Older

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9220 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction - erupted or exposed root	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 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	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

Exhibit B Benefits Covered for Adults – Age 21 and Older

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for Adults – Age 21 and Older

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois dental practice act as defined in the Illinois administrative code 1220.500, procedure codes D9241, D9242, and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure codes D9220 and D9221 require a dental sedation permit B in order to perform service.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Not covered with D0140 on same date of service.	
D9220	general anesthesia - first 30 minutes	21 and older		Yes	Permit B is required. Not allowed on the same date of service as D9230, D9241, D9242, or D9248.	narrative of medical necessity
D9221	general anesthesia - each additional 15 minutes	21 and older		Yes	Four of (D9221) per 1 Day(s) Per Provider OR Location. Not allowed on the same date of service with D9230, D9241, D9242 or D9248. Permit B is required.	narrative of medical necessity
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	21 and older		No	Not allowed on the same date of service as D9220, D9221, D9241, D9242, or D9248.	narrative of medical necessity
D9241	intravenous sedation/analgesia - first 30 minutes	21 and older		Yes	Permit A or B is required. Not allowed on same date of service as D9220, D9221, D9230, or D9248.	narrative of medical necessity
D9242	intravenous sedation/analgesia - each additional 15 minutes	21 and older		Yes	Four of (D9242) per 1 Day(s) Per Provider OR Location. Not allowed on the same date of service with D9220, D9221, D9230, or D9248. Permit A or B is required.	narrative of medical necessity
D9248	non-intravenous conscious sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9220, D9221, D9230, D9241, or D9242.	
D9310	consultation	21 and older		No		narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		narrative of medical necessity