



DentaQuest, LLC

Please Refer to Your Participation Agreement for Plans You are Contracted For

Mutual of Omaha Medicare Advantage

Office Reference Manual

PO Box 2906
Milwaukee, WI 53201-2906
800-436-5286
www.dentaquest.com

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**DentaQuest, LLC
Address and Telephone Numbers**

Customer Service/Provider Services

PO Box 2906
Milwaukee, WI 53201-2906
855-453-5287
Fax numbers:
 Claims/payment issues: 262-241-7379
 Claims to be processed: 262-834-3589
 All other: 262-834-3450
Claims questions:
 denclaims@DentaQuest.com
Eligibility or Benefit questions:
 denelig.benefits@DentaQuest.com

Customer Service/Member Services

MoO San Antonio	866-488-0249
MoO Cincinnati	877-603-0785
MoO El Paso	844-335-2918
MoO Denver	844-335-4178
MoO Dallas	844-335-3776

Plan Member Services

TX - 866-488-0249
OH/KY - 877-603-0785

TTY (Hearing Impaired)

711

Fraud Hotline

800-237-9139

Credentialing

PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800-233-1468
Fax: 262-241-4077

Claims should be sent to:

PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262-834-3589

Electronic Claims should be sent:

Direct entry on the web – www.dentaquest.com
Or,
Via Clearinghouse – Payer ID CX014

Include address on electronic claims –
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

Questions regarding electronic claims
submission:
Systems Operations Support: 888-560-8135



DentaQuest, LLC

Statement of Members Rights and Responsibilities

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

1. All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.
2. All Members have a right to respectful and competent treatment regardless of race, color, religion, gender, sexual preference, veteran status, disability, or national origin.
3. All Members have the right to know the identity and professional status of all persons providing their oral health care services.
4. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.
5. All Members have the right to fully participate in decisions concerning their dental care after receiving sufficient information to enable them to give informed consent before beginning any procedure and/or treatment.
6. All Members have the right to accept or refuse participation in research and educational projects affecting their care and/or treatment.
7. All Members have the right to refuse treatment, drugs or other procedures to the extent permitted by law and to be made aware of potential medical consequences of refusing treatment.
8. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
9. All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.
10. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.
11. All Members have the right to make recommendations regarding DentaQuest's members' rights and responsibilities policies.
12. All Members have the right to be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation.
13. All Members have a right to expect clean, safe, and accessible environment for receiving dental care services.

14. All Members have a right to have member literature and materials written in a manner that truthfully and accurately provides relevant information in a format that is readable and easily understood by the intended audience.
15. All Members have the right to have all records pertaining to dental care treated as confidential unless disclosure is necessary to interpret the application of the member's contract to dental care or unless disclosure is otherwise provided by law.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.
2. All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
3. All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.
4. All Members have the responsibility of being considerate and cooperative in dealing with staff.
5. All Members have the responsibility of scheduling appointments and arriving at their provider's office in time for scheduled visits. Members also have the responsibility to notify their provider's office within twenty-four (24) hours if they must cancel or will be late for a scheduled appointment.
6. All Members have the responsibility of designating an individual to act on their behalf and to authorize treatment in the event of incapacity.
7. All Members have the responsibility of reading and being aware of material distributed by the Plan explaining policies and procedures regarding services and benefits.



DentaQuest, LLC

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.
2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.
7. To be informed of the status of their credentialing or recredentialing application, upon request.

* * *

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



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1.00 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

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

1.02 Member Identification Card

Health plan members receive dental identification cards from the health plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

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

Sample Member I.D. Card:

			
Member Name Here ID 000000000 GROUP MUT00001 EFF DATE 00/00/0000 DOB 00/00/0000 CMS H6821 001>		MedicareRx <small>Prescription Drug Coverage</small> RxPCN MEDPRIME Rx Group LUMERISX Rx PREFERRED \$0/\$0/\$0/\$0/00% Rx NON-PREFERRED \$0/\$0/\$0/\$0/0% PCP Primary Care Physician PCP PHONE (000) 000-0000 PCP SPEC ER URG CARE [DENTAL] \$0 \$0 \$0 \$0	
		Customer Service: 1-000-000-0000 TTY: 711 Behavioral Health: (000) 000-0000 Dental: (000) 000-0000 Vision: (000) 000-0000 Pharmacies call: (000) 000-0000 Medical Claims Address: P.O. Box #5084 Troy, MI 48007 member.medicareadvantage.mutualofomaha.com	
		Please review your plan documents for services that require referral or prior authorization. Without prior approval, the claim may not be paid. For behavioral health or substance abuse authorizations, call the behavioral health number. Out of Area Healthcare providers must file claims to LOCAL plan	

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

1.03 DentaQuest Eligibility Systems

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

Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquest.com. Once you have entered the website, click on "Dentist". From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 800-436-5286. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service department at 855-453-5287 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare member by entering your 6 digit DentaQuest location number, the member's recipient identification number and an expected date of service. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at 855-453-5287
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

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

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 800-436-5286. They will be able to assist you in utilizing either system.

1.04 Provider Service Center (eligibility):

855-453-5287

2.00 Coverage Determinations, Appeals, and Grievances:

You have the right to appeal to DentaQuest if you think:

- We have not paid a bill for services that we should have paid
- We have not paid a paid in full for services that we should have paid
- We have not provided or arranged for you to receive care that is covered
- We stopped providing care that you still need

We normally have 30 calendar days to process your appeal for any requests for payment. In some cases, you have a right to request a faster appeal known as an Expedited 72-Hour Appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 calendar days for a standard appeal. If you ask for a fast appeal, we will decide if you get an expedited 72-hour fast appeal. If not, your appeal will be processed in 30 calendar days. If any physician asks for a fast appeal, and supports your request for a fast appeal, we must automatically give it to you.

You have the right to ask Mutual of Omaha CareAdvantage to review our decision by asking us for an appeal.

Plan Appeal: Ask Mutual of Omaha CareAdvantage for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an appeal with Mutual of Omaha CareAdvantage” for information on how to ask for a plan level appeal.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-866-488-0249 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

Important information about your appeal rights

There are 2 kinds of appeals with Mutual of Omaha CareAdvantage

Standard Appeal – We’ll give you a written decision on a standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within **60 days**.

Fast Appeal – We’ll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 days.

How to ask for an appeal with Mutual of Omaha Care Advantage

Step 1: You, your representative or your doctor must ask us for an appeal. Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- [Whether you want a standard or fast appeal (for a fast appeal, explain why you need one)]
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal) or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

Step 2: Mail, fax or deliver your appeal.

For a Standard Appeal:

Mutual of Omaha Medicare Advantage Company

Mailing Address:

PO Box 5084
Troy, MI 48007
Fax: 877-806-3973

In Person Delivery Address:

3300 Mutual of Omaha Plaza
Omaha, NE 68175

Get help & more information

- Mutual of Omaha Care Advantage (HMO): 1-866-488-0249 TTY: 711
Our hours of operation are 8 a.m. to 8 p.m., seven days a week
You may receive a messaging service on weekends April 1 through September 30 and holidays. Please leave a message and your call will be returned the next business day. www.mutualofomahacareadvantage.com
[ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-488-0249 (TTY: 711).]
- 1-800-MEDICARE (1-800-633-4227)
24 hours, 7 days a week.
TTY: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.

Support for Your Appeal

You are not required to submit additional information to support your request for services or payment for services already received. DentaQuest is responsible for gathering all the necessary medical information; however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions to support your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialist physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. DentaQuest will provide an opportunity for you to provide additional information in person or in writing.

Who May File An Appeal

1. You may file an appeal or have someone else file the appeal for you on your behalf. Any physician may file an expedited appeal on your behalf.
2. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:
 - a. Give us your name, your Medicare number and a statement, which appoints an individual as your representative. For example: I [*your name*] appoint [*name of representative*] to act as my representative in requesting an appeal from the M+C Organization and/or the Center for Medicare and Medicaid Services regarding the denial or discontinuation of medical services.
 - b. You must sign and date the statement.
 - c. Your representative must also sign and date this statement unless he/she is an attorney.
 - d. You must include this signed statement with your appeal.
3. A Non-Contracting Physician or other Provider who has furnished you a service may file a standard appeal of a denied claim if he/she completes a waiver of payment statement, which says he/she will not bill you regardless of the outcome of the appeal.
4. A court-appointed guardian or agent under a health care proxy can file the appeal to the extent provided under state law.

3.00 Provider Complaint and Claim Resolution Process:

3.01 Administrative Complaints

Complaints in reference to administrative functions policies and procedures of the Company and do not include claim denial issues.

3.01.1 Administrative complaints may be made verbally by calling DentaQuest at 855-453-5287.

3.02 Claim Resolution Process

Appeals in reference to a denial issued by Claims for any reason. Providers are offered 60 calendar days to file written appeals in reference to claim denials. DentaQuest will process provider claim appeals within 30 business days of receipt.

3.02.1 Claim Resolution Requests may be sent to DentaQuest in writing:

**DentaQuest, LLC
RE: Provider Claim Resolution
PO Box 2906
Milwaukee, WI 53201-2906**

4.00 Claim Submission Procedures (claim filing options)

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

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

4.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

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

To submit claims via the website, simply log on to www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 800.341.8478. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at 800-417-7140 or via e-mail at: EDITeam@greatdentalplans.com

4.02 Electronic Claim Submission via Clearinghouse

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

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

4.03 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

4.04 NPI Requirements for Submission of Electronic Claims

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

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

4.05 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.

- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

DentaQuest, LLC-Claims
PO Box 2906
Milwaukee, WI 53201-2906

4.06 Coordination of Benefits (COB)

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

4.07 Filing Limits

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

4.08 Receipt and Audit of Claims

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

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

4.09 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 that can be found on the website (www.dentaquest.com).
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

Via Fax – 262.241.4077

Via Mail – DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906
ATTN: PEC Department

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

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

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

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

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-7) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-7 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 800.508.6780 or via e-mail at denelig.benefits@DentaQuest.com.

5.01 HIPAA Companion Guide

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

6.00 Quality Improvement Program (Policies 200 Series)

DentaQuest administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes:

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

A copy of DentaQuest's QI Program is available upon request by contacting DentaQuest's Customer Service Department at 800-436-5286 or via e-mail at:

denelig.benefits@DentaQuest.com.

7.00 Credentialing (Policies 300 Series)

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

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry.

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

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

Appeal of Credentialing Committee Recommendations. (Policy 300.017)

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

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

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)

Network providers are recredentialed at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800-436-5286 or via e-mail at:

denelig.benefits@DentaQuest.com.

8.00 General Definitions

The following definitions apply to this Office Reference Manual:

- A. "Contract" means the document specifying the services provided by DentaQuest to:
- an employer, directly or on behalf of the State, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
 - a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicaid & Medicare Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").
- B. "Covered Services" is a dental service or supply that satisfies all of the following criteria:
- provided or arranged by a Participating Provider to a Member;
 - authorized by DentaQuest in accordance with the Plan Certificate; and
 - submitted to DentaQuest according to DentaQuest's filing requirements.
- C. "DentaQuest" shall refer to DentaQuest, LLC
- D. "DentaQuest Service Area" shall be defined as the State in which the member resides.
- 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 DHS law, regulations, guidelines and accepted standards of medical practice in the community.
- F. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."
- G. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.
- H. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members for a fixed prepaid fee.
- I. "Plan Certificate" means the document that outlines the benefits available to Members.
- J. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

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

9.01 Criteria for Dental Extractions

Dental adheres to the following policy for evaluating removal of teeth in order to maintain consistency throughout its dental networks.

Documentation needed for authorization procedure:

- Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth
- Tooth specific narrative demonstrating medical necessity
 - A decision regarding benefits is made on the basis of the documentation provided.
 - Treatment rendered without necessary pre-authorization is subject to retrospective review.
- Codes:
DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology Users Manual.

Criteria

- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
- The removal of primary teeth whose exfoliation is imminent is not a covered benefit.
- In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
- Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.
- Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.
- The extraction of primary or permanent teeth does not require authorization unless:
 - Teeth are impacted wisdom teeth
 - Residual roots requiring surgical removal
 - Surgical extraction of erupted teeth.
- Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

Documentation needed for authorization procedure:

- Diagnostic quality periapical and/or panoramic radiographs,

- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
- Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
- Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity that is tooth specific.

Authorization for extraction of impacted third molars:

- Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, D7240, and D7241. Benefit review decisions for authorization of the extraction of impacted third molar teeth are tooth specific.
- The prophylactic removal of disease-free third molars is not covered.
- Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
- Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
- Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
- Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.

Reference: American Association of Oral Maxillofacial Surgeons and American Dental Association**9.02 Criteria for Cast Crowns****Documentation needed for authorization of procedure:**

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

Criteria

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

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

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

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

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

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

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.

- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

9.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:

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

Criteria

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

Root canal therapy must meet the following criteria:

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

Authorizations for Root Canal therapy will not meet criteria if:

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

Other Considerations

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

9.04 Criteria for Stainless Steel Crowns

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

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.
- Copy of patient's dental record with complete caries charting and dental anomalies
- Copy of detailed treatment plan.

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

Criteria

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

Note: DentaQuest may require a second opinion for requests of more than 4 stainless steel crowns per patient.

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

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

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

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

Criteria for treatment using stainless steel crowns will not be met if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Member is age 6 or older and tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent pathologic destruction due to caries or trauma.

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

DentaQuest may deny coverage for the services for patients over age 21*.

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In Emergencies).

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

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

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

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

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

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

Criteria

In most situations, OR cases will be authorized for covered procedures if the following is (are) involved:

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

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

9.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Criteria

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

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full sized teeth.

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

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

9.06 Criteria for Fixed Prosthodontics

Documentation needed for authorization of procedure:

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

The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.

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

As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.

Authorizations for prosthesis do not meet criteria:

- **If appropriate documentation is not received documenting physical or neurological disorders precluding the placement of a removable prosthesis.**
- **If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.**
- **If abutment teeth are less than 50% supported in bone.**
- **If there are untreated cavities or active periodontal disease in the abutment teeth.**

9.07 Criteria for the Excision of Bone Tissue

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

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

Documentation needed for authorization of procedure:

- **Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.**

- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

9.08 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

9.09 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 will be authorized (for procedures covered by Health Plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

9.10 Criteria for Periodontal Treatment

Not all procedures require authorization.

Documentation needed for authorization of procedure:

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

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

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

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

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

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:
 - 1) Radiographic evidence of root surface calculus.
 - 2) Radiographic evidence of noticeable loss of bone support.

9.11 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 should include:

- informed consent;
- type of immobilization used;
- indication for immobilization;
- the duration of application.

Indications*:

- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to lack of maturity;
- patient who requires immediate diagnosis and/ or limited 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*:

- cooperative patient;
- patient who cannot be immobilized safely due to associated medical conditions.

Goals of Behavior Management*:

- establish communication;
- alleviate fear and anxiety;
- deliver quality dental care;
- build a trusting relationship between dentist and child;
- 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 dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**
2. **Dentists should not restrain children without formal training at a dental school or approved residency program.**
3. **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**
4. **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

9.06 Criteria for Fixed Prosthodontics

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for

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

The placement of a fixed prosthetic appliance will only be considered for those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis.

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

As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date for the denture service to be covered.

Authorizations for prosthesis do not meet criteria:

- If appropriate documentation is not received documenting physical or neurological disorders precluding the placement of a removable prosthesis.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If abutment teeth are less than 50% supported in bone.
- If there are untreated cavities or active periodontal disease in the abutment teeth.

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ www.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- Acknowledgment of Disclosure and Acceptance Member Financial Responsibility for Non-Covered Services Consent Form

The forms can also be found within this manual.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																		
2. Predetermination/Preauthorization Number						POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)												
3. Company/Plan Name, Address, City, State, Zip Code																		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																		
13. Date of Birth (MM/DD/CCYY)						14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																		
16. Plan/Group Number																		
17. Employer Name																		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																		
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																		
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)				19. Reserved For Future Use									
9. Plan/Group Number			10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other															
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																		
PATIENT INFORMATION																		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other																		
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																		
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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 System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty.	30. Description			31. Fee							
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
33. Missing Teeth Information (Place an 'X' on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)					31a. Other Fee(s)								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	34b. (Primary diagnosis in 'A') B _____ D _____		\$0.00
35. Remarks																		
AUTHORIZATIONS						ANCILLARY CLAIM/TREATMENT INFORMATION												
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 _____						38. Place of Treatment <input type="checkbox"/> (e.g. 11-office; 22-OP Hospital) (Use "Place of Service Codes for Professional Claims")						39. Enclosures (Y or N) <input type="checkbox"/>						
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 _____						40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)										
						42. Months of Treatment		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)								
						45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident												
						46. Date of Accident (MM/DD/CCYY)			47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)						TREATING DENTIST AND TREATMENT LOCATION INFORMATION												
48. Name, Address, City, State, Zip Code						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 _____												
49. NPI			50. License Number			51. SSN or TIN			54. NPI			55. License Number						
52. Phone Number						52a. Additional Provider ID			57. Phone Number			58. Additional Provider ID						
56. Address, City, State, Zip Code						56a. Provider Specialty Code												

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

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

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

ALLERGY	PRE MED	MEDICAL ALERT																														
INITIAL CLINICAL EXAM																																
PATIENT'S NAME _____ <table style="width: 100%; border: none; margin-left: 100px;"> <tr> <td style="text-align: center; border: none;">Last</td> <td style="text-align: center; border: none;">First</td> <td style="text-align: center; border: none;">Middle</td> </tr> </table>			Last	First	Middle																											
Last	First	Middle																														
	GINGIVA <hr/> MOBILITY <hr/> PROTHESIS EVALUATION <hr/> OCCLUSION 1 11 111 <hr/> PATIENT'S CHIEF COMPLAINT																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px; text-align: center;">OK</td> </tr> <tr><td>LYMPH NODES</td><td></td></tr> <tr><td>PHARYNX</td><td></td></tr> <tr><td>TONSILS</td><td></td></tr> <tr><td>SOFT PALATE</td><td></td></tr> <tr><td>HARD PALATE</td><td></td></tr> <tr><td>FLOOR OF MOUTH</td><td></td></tr> <tr><td>TONGUE</td><td></td></tr> <tr><td>VESTIBULES</td><td></td></tr> <tr><td>BUCCAL MUCOSA</td><td></td></tr> <tr><td>LIPS</td><td></td></tr> <tr><td>SKIN</td><td></td></tr> <tr><td>TMJ</td><td></td></tr> <tr><td>ORAL HYGIENE</td><td></td></tr> <tr><td>PERIO EXAM</td><td></td></tr> </table>		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 	
	OK																															
LYMPH NODES																																
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SKIN																																
TMJ																																
ORAL HYGIENE																																
PERIO EXAM																																
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.

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

Authorization for Dental Treatment

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

**AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS
DISBURSED BY DENTAQUEST**

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** 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)

MEDICAL AND DENTAL HISTORY

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 of breath, or because you are very tired? Yes

No

Do your ankles swell during the day? Yes No

Do you use more than two pillows to sleep? Yes No

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

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

Are you on a special diet? Yes No

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

If yes, please list: _____

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

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

Provider Update Form - Provider Operations

Section 1: Current Information - Complete for all requests

Provider Last Name: Provider First Name:
 Individual National Provider Identifier (NPI) #:
 Telephone Number: Credentialing E-mail:

Section 2: Name Change/Demographic Change

New Name (Last, First, MI):
 New Telephone Number: New Credentialing E-mail:
 Date of Birth: Social Security #: Gender: New Fax Number:

Section 3: Add a Location (*Updated W9 and contract are required for location updates.)

Location Name:
 Service Location Address:
 City: State: Zipcode:
 Telephone: Credentialing E-mail:
 Fax: Tax ID Number:
 New Location Office Hours: Ages: Languages: Handicapped accessible
 Primary Location
 Effective Date: Medicaid id number (if applicable):

Section 4: Credentialing Correspondence Address Change

Credentialing Contact Name:
 Credentialing Address:
 City: State: Zipcode:
 Telephone: Credentialing E-mail:
 Fax:

Section 5: Tax ID Change (*Updated W9 and contract are required for Tax ID number changes)

Old Tax ID Number: *New Tax ID Number:
 Business Name:
 Payment Address:

Section 6: Provider Status Change

Term provider at location listed below (Please attach document with any additional locations to be termed)
 Term provider at all locations - all networks (Please attach term letter, note or document from provider as applicable)
 Term Reason/Comments:
 Location Name:
 Service Location Address:
 City: State: Zipcode:

Section 7: Requestor Information

Requestor Name: Date:
 Requestor Title:
 Requestor Phone #: Email address:

Section 8: Notes

You may send this form by fax to 262-241-4077 or by email to StandardUpdates@dentaquest.com

Additional Location

*Updated W9 and contract (as applicable) are required for location updates.

Add Location Term of Existing Office

Location Name: _____

Service Location Address: _____

City: _____ State: _____ Zipcode: _____

Telephone: _____ Credentialing E-mail: _____

Fax: _____ Tax ID Number: _____

New Location Office Hours: _____ Ages: _____ Languages: _____ Handicapped accessible
Primary Location

Effective Date: _____ Medicaid id number (if applicable): _____

Additional Location

*Updated W9 and contract (as applicable) are required for location updates.

Add Location Term of Existing Office

Location Name: _____

Service Location Address: _____

City: _____ State: _____ Zipcode: _____

Telephone: _____ Credentialing E-mail: _____

Fax: _____ Tax ID Number: _____

New Location Office Hours: _____ Ages: _____ Languages: _____ Handicapped accessible
Primary Location

Effective Date: _____ Medicaid id number (if applicable): _____

Additional Location

*Updated W9 and contract (as applicable) are required for location updates.

Add Location Term of Existing Office

Location Name: _____

Service Location Address: _____

City: _____ State: _____ Zipcode: _____

Telephone: _____ Credentialing E-mail: _____

Fax: _____ Tax ID Number: _____

New Location Office Hours: _____ Ages: _____ Languages: _____ Handicapped accessible
Primary Location

Effective Date: _____ Medicaid id number (if applicable): _____

You may send this form by fax to 262-241-4077 or by email to StandardUpdates@dentaquest.com

Request for Transfer of Records

I, _____, hereby request and give my permission to
Dr. _____ to provide Dr. _____ any and all
information regarding past dental care for _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: _____

Address: _____

Phone: _____

**Acknowledgment of Disclosure and Acceptance
Member Financial Responsibility for Non-Covered Services
CONSENT FORM**

Member Name: _____

Member ID: _____

Treating Provider Name: _____
Service Location Name and Address: _____

Not all dental services are covered by your health plan. Some services are covered, but only within specific time frames (twice per year, once per year, once every 5 years, etc.) Services requested or received more frequently than your benefit allows are considered to be non-covered. Some services also have criteria that must be met to be covered. This is called "medical necessity". If the service is not medically necessary, the service is not covered. The following service(s) are recommended for the above named patient, but are not covered services:

Non-Covered Services

Code	Cost	Description	Reason service is not covered

I understand that the above services are not covered by my health plan, and that I am personally responsible for paying the dentist if I choose to receive these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

_____ Member Signature

_____ Date

_____ Witness Signature

APPENDIX B

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

855-453-5287

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

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

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

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

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
312-440-2500

**Mutual of Omaha Medicare Advantage
BENEFITS EFFECTIVE JANUARY 1, 2019
Benefit Design**

PREVENTATIVE PLANS

CareAdvantage Complete OH, CareAdvantage Complete KY Benefit Grid

Annual Deductible: N/A

Calendar Year Maximum: N/A

Out-of-Network Coverage: Services must be received from a network dentist. If a member receives services from an out-of-network dentist they will be responsible for all costs related to those services.

Category/Procedure	Benefit Limits	Member Pays
<i>Diagnostic</i>		
Periodic Oral Evaluations	Two every calendar year	\$25 copayment per visit
Horizontal Bitewing X-Ray Images (up to four)	Once every calendar year	\$25 copayment per visit
<i>Preventive</i>		
Routine Cleaning	Two every calendar year	\$25 copayment per visit
Fluoride Treatments	One every calendar year	\$25 copayment per visit

CareAdvantage Complete (CO), CareAdvantage Rewards (TX)

Annual Deductible: N/A

Calendar Year Maximum: N/A

Out-of-Network Coverage: Services must be received from a network dentist. If a member receives services from an out-of-network dentist they will be responsible for all costs related to those services.

Category/Procedure	Benefit Limits	Member Pays
<i>Diagnostic</i>		
Periodic Oral Evaluations	Two every calendar year	\$0 copayment per visit
Horizontal Bitewing X-Ray Images (up to four)	Once every calendar year	\$0 copayment per visit
<i>Preventive</i>		
Routine Cleaning	Two every calendar year	\$0 copayment per visit
Fluoride Treatments	One every calendar year	\$0 copayment per visit

Comprehensive Plan

**CareAdvantage Plus Benefit Grid (OH/KY), CareAdvantage Complete (TX),
CareAdvantage Plus (CO)**

Annual Deductible: \$100 deductible each year. The deductible is waived for diagnostic and preventive services.

Calendar Year Maximum: \$1,000 is the total amount the plan will pay for covered services in the calendar year. Applies to all services.

Out-of-Network Coverage: Services must be received from a network dentist. If a member receives services from an out-of-network dentist they will be responsible for all costs related to those services.

Category/Procedure	Benefit Limits	Member Pays
Diagnostic		
Comprehensive Oral Exam	Once every 3 calendar years	Covered in full, applies to the annual maximum
Periodic Oral Evaluation	Two every calendar year	Covered in full, applies to the annual maximum
Limited Oral Evaluation	Three every calendar year	Covered in full, applies to the annual maximum
Intraoral X-Ray Image of the Entire Mouth (full mouth series or panoramic image)	Once every 3 calendar years	Covered in full, applies to the annual maximum
Bitewing X-Ray Images	Once every calendar year	Covered in full, applies to the annual maximum
Preventive		
Routine Cleaning	Two every calendar year	Covered in full, applies to the annual maximum
Periodontal Maintenance (following active therapy)	Four every calendar year	Covered in full, applies to the annual maximum
Fluoride Treatments	Two every calendar year	Covered in full, applies to the annual maximum
Basic Restorative		
Amalgam Fillings	Once per tooth every 2 calendar years	20% coinsurance after deductible is met, applies to the annual maximum
Resin Fillings	Once per tooth every 2 calendar years	20% coinsurance after deductible is met, applies to the annual maximum
Inlays/Onlays	Once per tooth every 5 calendar years	20% coinsurance after deductible is met, applies to the annual maximum
Protective Restorations	Once per tooth per lifetime	20% coinsurance after deductible is met, applies to the annual maximum
Oral Surgery		
Simple Extractions	Once per tooth per lifetime	20% coinsurance after deductible is met, applies to the annual maximum
Surgical Extractions	Once per tooth per lifetime	20% coinsurance after deductible is met, applies to the annual maximum
Other Surgical Procedures including Alveoloplasty and Vestibuloplasty	One per quadrant or arch per lifetime	50% coinsurance after deductible is met, applies to the annual maximum

Category/Procedure	Benefit Limits	Member Pays
<i>Periodontics</i>		
Periodontal Surgery	Once per quadrant every 3 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
Scaling and Root Planing	Once per quadrant every 3 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
Full Mouth Debridement	One every 3 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
<i>Endodontics</i>		
Root Canal Treatment	Once per tooth per lifetime	50% coinsurance after deductible is met, applies to the annual maximum
Retreatment Root Canal Therapy	Once per tooth per lifetime	50% coinsurance after deductible is met, applies to the annual maximum
Apicoectomy	Once per tooth per lifetime	50% coinsurance after deductible is met, applies to the annual maximum
Pulpotomy	Once per tooth per lifetime	50% coinsurance after deductible is met, applies to the annual maximum
<i>Prosthetic Maintenance</i>		
Bridge or Denture Repair	Once per arch every calendar year	20% coinsurance after deductible is met, applies to the annual maximum
Adjustment to Dentures	Two adjustments per arch every calendar year	20% coinsurance after deductible is met, applies to the annual maximum
Tissue Conditioning	Allowed in conjunction with fabrication of new denture	20% coinsurance after deductible is met, applies to the annual maximum
Repair, Replace or Add Teeth to Existing Partial or Full Dentures	Once per tooth every calendar year	20% coinsurance after deductible is met, applies to the annual maximum
Rebase or Reline of Dentures	Once per denture every 3 calendar years	20% coinsurance after deductible is met, applies to the annual maximum
Recement Bridges, Crowns, Onlays and Inlays Crowns	Once per tooth every two calendar years	20% coinsurance after deductible is met, applies to the annual maximum
<i>Adjunct General Services</i>		
Minor Treatment for Pain Relief (emergency)		Covered in full, applies to the annual maximum

Category/Procedure	Benefit Limits	Member Pays
General Anesthesia	When clinically necessary	50% coinsurance after deductible is met, applies to the annual maximum
Major Restoratives		
Prosthodontics		
Dentures	Complete, partial or immediate once every 5 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
Fixed Bridges	Once per tooth every 5 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
Crowns		
Crowns	Once per tooth every 5 calendar years	50% coinsurance after deductible is met, applies to the annual maximum
Post and Core or Crown Buildup	Once per tooth every 5 calendar years	50% coinsurance after deductible is met, applies to the annual maximum

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	All Ages		No	Two of (D0120, D0160, D0170) per 1 Calendar year(s) Per patient.	
D0140	limited oral evaluation-problem focused	All Ages		No	Three of (D0140) per 1 Calendar year(s) Per patient. Not allowed with routine services.	
D0150	comprehensive oral evaluation - new or established patient	All Ages		No	One of (D0150, D0180) per 3 Calendar year(s) Per Provider OR Location. One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	All Ages		No	Two of (D0120, D0160, D0170) per 1 Calendar year(s) Per patient.	
D0170	re-evaluation, limited problem focused	All Ages		No	Two of (D0120, D0160, D0170) per 1 Calendar year(s) Per patient.	
D0180	comprehensive periodontal evaluation - new or established patient	All Ages		No	One of (D0150, D0180) per 3 Calendar year(s) Per Provider OR Location. One of (D0120, D0150, D0180) per 6 Month(s) Per Provider OR Location.	
D0210	intraoral - complete series of radiographic images	All Ages		No	One of (D0210, D0277, D0330) per 3 Calendar year(s) Per patient.	
D0220	intraoral - periapical first radiographic image	All Ages		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	All Ages		No		
D0240	intraoral - occlusal radiographic image	All Ages		No	Two of (D0240) per 2 Calendar year(s) Per patient.	
D0270	bitewing - single radiographic image	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	All Ages		No	One of (D0210, D0277, D0330) per 3 Calendar year(s) Per patient.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	panoramic radiographic image	All Ages		No	One of (D0210, D0277, D0330) per 3 Calendar year(s) Per patient.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	All Ages		No	Two of (D1110, D4346, D4910) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	All Ages		No	Two of (D1206, D1208, D9910) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	All Ages		No	Two of (D1206, D1208, D9910) per 1 Calendar year(s) Per patient.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2150	Amalgam - two surfaces, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2160	amalgam - three surfaces, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2161	amalgam - four or more surfaces, primary or permanent	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2330	resin-based composite - one surface, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2331	resin-based composite - two surfaces, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2332	resin-based composite - three surfaces, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2390	resin-based composite crown, anterior	All Ages	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2391	resin-based composite - one surface, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2393	resin-based composite - three surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2394	resin-based composite - four or more surfaces, posterior	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2510	inlay - metallic -1 surface	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2520	inlay-metallic-2 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2530	inlay-metallic-3+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2542	onlay - metallic - two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2543	onlay-metallic-3 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2544	onlay-metallic-4+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2610	inlay-porce/ceramic-1surface	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2620	inlay-porcelain/ceramic-2 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2630	inlay-porc/ceramic 3+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2642	onlay-porcelain/ceramic-2 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2643	onlay-porcelain/ceramic-3 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2644	onlay-porcelain/ceramic-4+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2650	inlay-composite/resin 1surface	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2651	inlay-composite/resin-2 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2652	inlay-composite/resin-3+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2662	onlay-composite/resin-2 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2663	onlay-composite/resin-3 surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2664	onlay-composite/resin-4+ surfaces	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2710	crown - resin-based composite (indirect)	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2712	crown - 3/4 resin-based composite (indirect)	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2720	crown-resin with high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2721	crown - resin with predominantly base metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2722	crown - resin with noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2740	crown - porcelain/ceramic	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2750	crown - porcelain fused to high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2751	crown - porcelain fused to predominantly base metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2752	crown - porcelain fused to noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2780	crown - ¾ cast high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2781	crown - ¾ cast predominantly base metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2782	crown - ¾ cast noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2783	crown - ¾ porcelain/ceramic	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2790	crown - full cast high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2791	crown - full cast predominantly base metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2792	crown - full cast noble metal	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2794	Crown- Titanium and Titanium Alloys	All Ages	Teeth 1 - 32	Yes	One of (D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 5 Calendar year(s) Per patient per tooth. Pre-operative periapical radiograph	
D2799	provisional crown	All Ages	Teeth 1 - 32	No	Disallow - included in the crown benefit	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	All Ages	Teeth 1 - 32	No	One of (D2910) per 2 Calendar year(s) Per patient per tooth. Only after 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	All Ages	Teeth 1 - 32	No	One of (D2915) per 2 Calendar year(s) Per patient per tooth. Only after 6 months of initial placement.	
D2920	re-cement or re-bond crown	All Ages	Teeth 1 - 32, A - T	No	One of (D2920) per 2 Calendar year(s) Per patient per tooth. Only after 6 months of initial placement.	
D2940	protective restoration	All Ages	Teeth 1 - 32, A - T	No	One of (D2940) per 1 Lifetime Per patient per tooth.	
D2950	core buildup, including any pins when required	All Ages	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 5 Calendar year(s) Per patient per tooth. Deny when billed with resin or amalgam restoration.	
D2951	pin retention - per tooth, in addition to restoration	All Ages	Teeth 1 - 32	No	One of (D2951) per 5 Calendar year(s) Per patient per tooth. With resin or amalgam restoration. Deny D2951 as included in D2950, D2952, D2954 if billed separately.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2952	cast post and core in addition to crown	All Ages	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 5 Calendar year(s) Per patient per tooth. Deny when billed with resin or amalgam restoration.	
D2953	each additional cast post - same tooth	All Ages	Teeth 1 - 32	No	One of (D2953) per 5 Calendar year(s) Per patient per tooth. When billed with D2952.	
D2954	prefabricated post and core in addition to crown	All Ages	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 5 Calendar year(s) Per patient per tooth. Deny when billed with resin or amalgam restoration.	
D2980	crown repair, by report	All Ages	Teeth 1 - 32	No	One of (D2980) per 2 Calendar year(s) Per patient per tooth. Only after 6 months of initial placement.	
D2990	Resin infiltration of incipient smooth surface lesions	All Ages	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2990) per 2 Calendar year(s) Per patient per tooth, per surface. Do not allow any of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 once D2390 or other crown service paid.	
D2999	unspecified restorative procedure, by report	All Ages	Teeth 1 - 32, A - T	Yes	Narrative of medical necessity and description of service	

Exhibit A Benefits Covered for Comprehensive Plan

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	All Ages	Teeth 1 - 32, A - T	No	One of (D3220, D3221) per 1 Lifetime Per patient per tooth. Not allowed in conjunction with root canal therapy by same provider/location within 90 days.	
D3221	pulpal debridement, primary and permanent teeth	All Ages	Teeth 1 - 32, A - T	No	One of (D3220, D3221) per 1 Lifetime Per patient per tooth. Not allowed in conjunction with root canal therapy by same provider/location within 90 days.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	All Ages	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	All Ages	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	All Ages	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3331	treatment of root canal obstruction; non-surgical access	All Ages	Teeth 1 - 32	No	One of (D3331) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	All Ages	Teeth 6 - 11, 22 - 27	No	One of (D3346) per 1 Lifetime Per patient per tooth.	
D3347	retreatment of previous root canal therapy - premolar	All Ages	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3347) per 1 Lifetime Per patient per tooth.	
D3348	retreatment of previous root canal therapy-molar	All Ages	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3348) per 1 Lifetime Per patient per tooth.	
D3410	apicoectomy - anterior	All Ages	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D3421	apicoectomy - premolar (first root)	All Ages	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D3425	apicoectomy - molar (first root)	All Ages	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D3426	apicoectomy (each additional root)	All Ages	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D3430	retrograde filling - per root	All Ages	Teeth 1 - 32	Yes	One of (D3430) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D3999	unspecified endodontic procedure, by report	All Ages	Teeth 1 - 32, A - T	Yes	Narrative of medical necessity and description of service	

Exhibit A Benefits Covered for Comprehensive Plan

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 3 Calendar year(s) Per patient per quadrant. Radiographs, perio charting and photographs	
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 3 Calendar year(s) Per patient per quadrant. Radiographs, perio charting and photographs	
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4249	clinical crown lengthening - hard tissue	All Ages	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Radiographs and perio charting	
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4341	periodontal scaling and root planing - four or more teeth per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Radiographs and perio charting	
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	All Ages		No	Two of (D1110, D4346, D4910) per 1 Calendar year(s) Per patient.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	All Ages		No	One of (D4355) per 3 Calendar year(s) Per patient.	
D4910	periodontal maintenance procedures	All Ages		No	Four of (D4910) per 1 Calendar year(s) Per patient.	
D4999	unspecified periodontal procedure, by report	All Ages		Yes	Narrative of medical necessity and description of service	

Exhibit A Benefits Covered for Comprehensive Plan

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5120	complete denture - mandibular	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5130	immediate denture - maxillary	All Ages		No	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5140	immediate denture - mandibular	All Ages		No	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5221) per 1 Lifetime Per patient. One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5222) per 1 Lifetime Per patient. One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5223) per 1 Lifetime Per patient. One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	All Ages		No	One of (D5224) per 1 Lifetime Per patient. One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5225	maxillary partial denture-flexible base	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5226	mandibular partial denture-flexible base	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs in patients record	
D5410	adjust complete denture - maxillary	All Ages		No	Two of (D5410) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5411	adjust complete denture - mandibular	All Ages		No	Two of (D5411) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	
D5421	adjust partial denture-maxillary	All Ages		No	Two of (D5421) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	
D5422	adjust partial denture - mandibular	All Ages		No	Two of (D5422) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	
D5511	repair broken complete denture base, mandibular	All Ages		No	One of (D5511) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	
D5512	repair broken complete denture base, maxillary	All Ages		No	One of (D5512) per 1 Calendar year(s) Per patient per arch. (After 6 months have elapsed since initial placement).	
D5520	replace missing or broken teeth - complete denture (each tooth)	All Ages	Teeth 1 - 32	No	One of (D5520) per 1 Calendar year(s) Per patient per tooth. (After 6 months have elapsed since initial placement).	
D5611	repair resin partial denture base, mandibular	All Ages		No	One of (D5611) per 1 Calendar year(s) Per patient per arch.	
D5612	repair resin partial denture base, maxillary	All Ages		No	One of (D5612) per 1 Calendar year(s) Per patient per arch.	
D5621	repair cast partial framework, mandibular	All Ages		No	One of (D5621) per 1 Calendar year(s) Per patient per arch.	
D5622	repair cast partial framework, maxillary	All Ages		No	One of (D5622) per 1 Calendar year(s) Per patient per arch.	
D5630	repair or replace broken retentive/clasping materials per tooth	All Ages	Teeth 1 - 32	No	One of (D5630) per 1 Calendar year(s) Per patient per tooth.	
D5640	replace broken teeth-per tooth	All Ages	Teeth 1 - 32	No	One of (D5640) per 1 Calendar year(s) Per patient per tooth.	
D5650	add tooth to existing partial denture	All Ages	Teeth 1 - 32	No	One of (D5650) per 1 Calendar year(s) Per patient per tooth.	
D5660	add clasp to existing partial denture	All Ages	Teeth 1 - 32	No	One of (D5660) per 1 Calendar year(s) Per patient per tooth.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, removable

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5710	rebase complete maxillary denture	All Ages		No	One of (D5710, D5730, D5750) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5711	rebase complete mandibular denture	All Ages		No	One of (D5711, D5731, D5751) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5720	rebase maxillary partial denture	All Ages		No	One of (D5720, D5740, D5760) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5721	rebase mandibular partial denture	All Ages		No	One of (D5721, D5741, D5761) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5730	reline complete maxillary denture (chairside)	All Ages		No	One of (D5710, D5730, D5750) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5731	reline complete mandibular denture (chairside)	All Ages		No	One of (D5711, D5731, D5751) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5740	reline maxillary partial denture (chairside)	All Ages		No	One of (D5720, D5740, D5760) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5741	reline mandibular partial denture (chairside)	All Ages		No	One of (D5721, D5741, D5761) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5750	reline complete maxillary denture (laboratory)	All Ages		No	One of (D5710, D5730, D5750) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5751	reline complete mandibular denture (laboratory)	All Ages		No	One of (D5711, D5731, D5751) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	All Ages		No	One of (D5720, D5740, D5760) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5761	reline mandibular partial denture (laboratory)	All Ages		No	One of (D5721, D5741, D5761) per 3 Calendar year(s) Per patient. (After 6 months have elapsed since initial placement).	
D5850	tissue conditioning, maxillary	All Ages		No	Only allowed in conjunction with fabrication of new denture. Not allowed for 5 calendar years after delivery of new denture	
D5851	tissue conditioning,mandibular	All Ages		No	Only allowed in conjunction with fabrication of new denture. Not allowed for 5 calendar years after delivery of new denture	
D5863	Overdenture - complete maxillary	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs and narrative in patients record	
D5864	Overdenture - partial maxillary	All Ages		No	One of (D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5863, D5864) per 5 Calendar year(s) Per patient. Pre-operative radiographs and narrative in patients record	
D5865	Overdenture - complete mandibular	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs and narrative in patients record	
D5866	Overdenture - partial mandibular	All Ages		No	One of (D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5865, D5866) per 5 Calendar year(s) Per patient. Pre-operative radiographs and narrative in patients record	
D5876	add metal substructure to acrylic full denture (per arch)	All Ages	Per Arch (01, 02, LA, UA)	No	Only allowed on the same date of service as D5110, D5120, D5130, D5140. Pre-operative radiographs in patients record.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5899	unspecified removable prosthodontic procedure, by report	All Ages		Yes	Pre-operative radiographs and narrative	

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5999	unspecified maxillofacial prosthesis, by report	All Ages		Yes	Narrative of medical necessity and description of service	

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6205	pontic - indirect resin based composite	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6210	pontic - cast high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6211	pontic-cast base metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6212	pontic - cast noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6214	Pontic - titanium and titanium alloys	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6240	pontic-porcelain fused-high noble	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6241	pontic-porcelain fused to base metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6242	pontic-porcelain fused-noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6243	Pontic - Porcelain fused to titanium and titanium alloys	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6245	prosthodontics fixed, pontic - porcelain/ceramic	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6250	pontic-resin with high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6251	pontic-resin with base metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6252	pontic-resin with noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6545	retainer - cast metal fixed	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6549	Resin retainer-For resin bonded fixed prosthesis	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6602	inlay - cast high noble metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6603	inlay - cast high noble metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6604	inlay - cast predominantly base metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6605	inlay - cast predominantly base metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6606	inlay - cast noble metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6607	inlay - cast noble metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6608	onlay - porcelain/ceramic, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6609	onlay - porcelain/ceramic, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6610	onlay - cast high noble metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6611	onlay - cast high noble metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6612	onlay - cast predominantly base metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6613	onlay - cast predominantly base metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6614	onlay - cast noble metal, two surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6615	onlay - cast noble metal, three or more surfaces	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6624	inlay - titanium	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6634	onlay - titanium	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6710	crown - indirect resin based composite	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6720	crown-resin with high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6721	crown-resin with base metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6722	crown-resin with noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6740	retainer crown – porcelain/ceramic	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6750	crown-porcelain fused high noble	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6751	crown-porcelain fused to base metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6752	crown-porcelain fused noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6780	crown-3/4 cst high noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6782	prosthodontics fixed, crown ¾ cast noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	All Ages		Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6790	crown-full cast high noble	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6791	crown - full cast base metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6792	crown - full cast noble metal	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6793	provisional retainer crown	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6794	Retainer crown - titanium and titanium alloys	All Ages	Teeth 1 - 32	Yes	One of (D6545, D6548, D6549, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6784, D6790, D6791, D6792, D6793, D6794) per 5 Calendar year(s) Per patient per tooth. Pre-operative radiographs	
D6930	re-cement or re-bond fixed partial denture	All Ages		No	One of (D6930) per 2 Calendar year(s) Per patient. Only after 6 months of initial placement.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6980	fixed partial denture repair	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D6980) per 2 Calendar year(s) Per patient per quadrant. Only after 6 months of initial placement.	
D6999	fixed prosthodontic procedure	All Ages	Teeth 1 - 32	Yes	Narrative of medical necessity and description of service	

**Exhibit A Benefits Covered for
Comprehensive Plan**

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All Ages	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 (D7210) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7220	removal of impacted tooth-soft tissue	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7220) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7230	removal of impacted tooth-partially bony	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7230) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7240	removal of impacted tooth-completely bony	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7240) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7241) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7250	surgical removal of residual tooth roots (cutting procedure)	All Ages	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 (D7250) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	All Ages	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 (D7251) per 1 Lifetime Per patient per tooth. Pre-operative radiographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7260	oroantral fistula closure	All Ages		No	Two of (D7260) per 1 Lifetime Per patient per arch.	
D7261	primary closure of a sinus perforation	All Ages		No	Two of (D7261) per 1 Lifetime Per patient per arch.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	All Ages		No		
D7286	incisional biopsy of oral tissue-soft	All Ages		No		
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Pre-operative radiographs	
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Pre-operative radiographs	
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Pre-operative radiographs	
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Pre-operative radiographs	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	All Ages	Per Arch (01, 02, LA, UA)	No	One of (D7340) per 1 Lifetime Per patient per arch.	
D7350	vestibuloplasty - ridge extension	All Ages	Per Arch (01, 02, LA, UA)	No	One of (D7350) per 1 Lifetime Per patient per arch.	
D7410	radical excision - lesion diameter up to 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7411	excision of benign lesion greater than 1.25 cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	All Ages		Yes	Narrative of medical necessity and description of service	
D7471	removal of exostosis - per site	All Ages	Per Arch (01, 02, LA, UA)	Yes	Two of (D7471) per 1 Lifetime Per patient per arch. regardless of the provider.	
D7472	removal of torus palatinus	All Ages		Yes	One of (D7472) per 1 Lifetime Per patient. regardless of the provider.	
D7473	removal of torus mandibularis	All Ages		Yes	Two of (D7473) per 1 Lifetime Per patient. regardless of the provider.	
D7485	surgical reduction of osseous tuberosity	All Ages		Yes	Two of (D7485) per 1 Lifetime Per patient. regardless of the provider.	
D7510	incision and drainage of abscess - intraoral soft tissue	All Ages	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	Not allowed in conjunction with extraction on same date of service.	
D7520	incision and drainage of abscess - extraoral soft tissue	All Ages		No		
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All Ages		No		
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	All Ages		No	One of (D7960, D7963) per 1 Lifetime Per patient per arch. Narrative and photographs	
D7963	frenuloplasty	All Ages		No	One of (D7960, D7963) per 1 Lifetime Per patient per arch. Narrative and photographs	
D7970	excision of hyperplastic tissue - per arch	All Ages	Per Arch (01, 02, LA, UA)	No	One of (D7970) per 1 Lifetime Per patient per arch. Narrative, radiographs and photographs	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7971	excision of pericoronal gingiva	All Ages	Teeth 1 - 32	No	One of (D7971) per 1 Lifetime Per patient per tooth. Narrative, radiographs and photographs	
D7999	unspecified oral surgery procedure, by report	All Ages		Yes	Narrative of medical necessity and description of service	

Exhibit A Benefits Covered for Comprehensive Plan

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	All Ages		No	Not allowed with anything other than D0140 and x-rays.	
D9222	deep sedation/general anesthesia first 15 minutes	All Ages		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed with (D9239, D9243) on the same day. Narrative, treatment record (including anesthesia records).	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	All Ages		Yes	Three of (D9223) per 1 Day(s) Per patient. Not allowed with (D9239, D9243) on the same day. Narrative, treatment record (including anesthesia records).	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	All Ages		Yes	One of (D9230) per 1 Day(s) Per patient. Not allowed with (D9222, D9223, D9239, D9243, D9248) on the same day. Narrative, treatment record (including anesthesia records).	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	All Ages		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed with (D9222, D9223) on the same day. Narrative, treatment record (including anesthesia records).	
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	All Ages		Yes	Three of (D9243) per 1 Day(s) Per patient. Not allowed with (D9222, D9223) on the same day. Narrative, treatment record (including anesthesia records).	
D9248	non-intravenous moderate (conscious) sedation	All Ages		Yes	One of (D9248) per 1 Day(s) Per patient. Not allowed with (D9222, D9223, D9230, D9239, D9243) on the same day. Narrative, treatment record (including anesthesia records).	
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	All Ages		No	One of (D9310) per 1 Year(s) Per Provider OR Location. Not allowed with (D0120, D0140, D0150, D0160, D0170, D0180) by same provider or location.	
D9410	house/extended care facility call	All Ages		No	One of (D9410) per 1 Day(s) Per patient. Six of (D9410) per 1 Calendar year(s) Per patient.	
D9420	hospital or ambulatory surgical center call	All Ages		No	One of (D9420) per 1 Day(s) Per patient. Six of (D9420) per 1 Calendar year(s) Per patient.	

**Exhibit A Benefits Covered for
Comprehensive Plan**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9910	application of desensitizing medicament	All Ages		No	Two of (D1206, D1208, D9910) per 1 Calendar year(s) Per patient.	
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	All Ages		Yes	One of (D9930) per 1 Year(s) Per patient. Not to be used for routine post-operative care or dry socket treatment. Narrative of medical necessity and description of service.	
D9950	occlusion analysis-mounted case	All Ages		Yes	One of (D9950, D9952) per 5 Calendar year(s) Per patient. Narrative of medical necessity and description of service	
D9951	occlusal adjustment - limited	All Ages		Yes	One of (D9951) per 1 Calendar year(s) Per patient. Narrative of medical necessity and description of service	
D9952	occlusal adjustment - complete	All Ages		Yes	One of (D9950, D9952) per 5 Calendar year(s) Per patient. Narrative of medical necessity and description of service	
D9999	unspecified adjunctive procedure, by report	All Ages		Yes	Narrative of medical necessity and description of service	

**Exhibit B Benefits Covered for
Preventative Plan - OH/KY**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	All Ages		No	Two of (D0120, D0140, D0150) per 1 Calendar year(s) Per patient.	
D0140	limited oral evaluation-problem focused	All Ages		No	Two of (D0120, D0140, D0150) per 1 Calendar year(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	All Ages		No	Two of (D0120, D0140, D0150) per 1 Calendar year(s) Per patient. One of (D0120, D0140, D0150) per 1 Calendar year(s) Per Provider OR Location.	
D0270	bitewing - single radiographic image	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	All Ages		No	One of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per patient.	

**Exhibit B Benefits Covered for
Preventative Plan - OH/KY**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	All Ages		No	Two of (D1110) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	All Ages		No	One of (D1208) per 1 Calendar year(s) Per patient.	