



DentaQuest, LLC

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

Magnolia Health Plan

Office Reference Manual

12121 N. Corporate Parkway
Mequon, WI 53092
800-235-6147
www.DentaQuest.com

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DentaQuest, LLC
Address and Telephone Numbers

Provider Services

12121 N. Corporate Parkway
Mequon, WI 53092
800.235.6147
Hours: Monday – Friday 8:00 am – 5:00 pm
(central)
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

Magnolia Health Plan
888.291.3760

TDD (Hearing Impaired)

877.725.7753

Special Needs Member Services

800.207.1262

Fraud Hotline

800.237.9139

Credentialing:

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

Authorizations should be sent to:

DentaQuest-Authorizations
12121 N. Corporate Parkway
Mequon, WI 53092

Claims should be sent to:

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



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/Plan'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 Plan 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.
8. To be informed at least 30 to 60 days in advance of any proposed amendments to CCO rules, regulations, policies and procedures, which allows the provider an opportunity to review, comment and adapt as possible to the proposed changes.
9. The provider manual references compliance with certain Federal regulations, and the Agreements indicate required compliance with applicable Federal regulations. We recommend requiring reference to applicable 42 CFR requirements also. Additionally, we recommend adding language in the Agreement specific to the following:
10. A requirement that CCO must not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that Provider has a practice that includes a substantial number of patients with expensive medical conditions.
11. A requirement that CCO must not exclude a Provider from CCO's Provider Network because Provider advocated on behalf of a Member for Medically Necessary and appropriate health care consistent with degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.
12. Notification of the prohibition and sanctions for submission of false Claims and statements.
13. A requirement that CCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including:

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14. Information regarding the nature of treatment options.
 15. Risks of treatment.
 16. Alternative treatments.
 17. The availability of alternative therapies, consultation or tests that may be self-administered.
 18. A requirement that CCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.
 19. A requirement that the CCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on a Member's behalf.
 20. A clause which specifies that agreement will not be construed as requiring CCO to provide, reimburse for, or provide coverage of, a counseling or referral service if Provider objects to provision of such services on moral or religious grounds.
 21. A continuation of benefits provision in the Rights and Obligations Upon Termination which states that the Provider agrees that in the event of the CCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CCO's Members through the period for which the Capitation has been paid.
 22. Language which requires the Provider to disclose annually any Physician Incentive Plan (PIP) or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the CCO and the physician or physician group.

DentaQuest, LLC

Member Confidentiality and Release of Information

As a reminder to all providers, information from members' medical records and from physicians or hospitals must be kept confidential in accordance with Federal and State law. Magnolia Health Plan recognizes that members have the right to have their health and medical information kept confidential, and we are committed to protecting access to our members' medical information. Magnolia Health Plan has defined confidential information in our policy as:

1. Clinical information communicated to a physician, or other health care provider, in his/her professional capacity, included in the medical record and directly related to a member's diagnosis and treatment.
2. Data included in the computer or system that is directly related to member's diagnosis and treatment, such as claims information, information collected in the course of Utilization/ Case Management or other processes.
3. Member-identifiable secondary health information abstracted from the medical records/ computer database for indexes and statistics.
4. Member information collected through the enrollment process or generated through Marketing.

A properly completed authorization signed by the member is required for release of all health information except:

- as required by Federal or State laws, court orders, or subpoenas
- for release to another health care provider currently involved in the care of the member
- as outline in the member's individual or group contract; and
- contractual obligations related to Quality Improvement or Utilization Management analysis.

The following are examples of some of the other situations your office may encounter on a day-to-day basis with some suggestions on how to maintain member confidentiality in these situations:

- **Telephone inquiries.** Avoid disclosing confidential patient information over the telephone because you have no idea who you are actually speaking with. Anyone can **claim** to be a physician or the patient's relative. If you have the patient's permission to release the information, you should obtain identifying information (e.g. medical record number, address, date of birth, etc.) before giving out any information over the telephone.
- **Phone messages to a patient's home or place of employment.** Leaving messages containing health information with another person or on an answering machine at the patient's home or at work may violate the patient's privacy, unless he/she has authorized you to do so. Leave your name, phone number and place of employment and ask the patient to return your call. If you know that you will need to call the patient back with advice or test results later in the day, ask the patient if you can leave a message on their answering machine or with another member of their family in the event they are not available. Document they gave you verbal consent to do so.
- **Reporting test results by mail.** All correspondence that contains health information (e.g. test results, appointment reminders) should be mailed to patients in a sealed envelope or post card that can be sealed in some manner.
- **Conversations in social settings.** Be aware of your surroundings. A patient's neighbor, relative or colleague may be in the elevator with you, sitting next to you at lunch, or following you out the door as you leave the office.

- **Store medical records in a secure manner.** Medical records, test results, consultant reports, etc. should not be left on desks or counters where unauthorized persons may see them. In addition, medical information on computer screens should not be visible to passersby. Always return your computer screen to the main menu or adjust the contrast if you have to leave your work area for any reason.

* * *

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

**Office Reference Manual
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Magnolia Health Plan Adult Benefits Exhibit B

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

Members receive identification cards from their 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.

Members will receive an ID Card from their Magnolia Health Plan prior to the effective enrollment date, but no later than seven (7) days after the Member's effective date of enrollment.

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 Magnolia Health Plan identification card is not dated and it does not need to be returned to Magnolia Health Plan should a Member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in Magnolia Health Plan.**



Member Name: Jane Doe
Medicaid ID#: XXXXXXXXXXXX

PCP Name: John Doe
PCP Number: XXX-XXX-XXXX

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Magnolia NurseWise® toll-free at 1-866-912-6285 (TDD/TTY 1-877-725-7753 or Mississippi Relay Services at 711). NurseWise is open 24 hours a day.

Rx: US Script
BIN:008019

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MEMBERS:

Member Services line 1-866-912-6285
TDD/TTY 1-877-725-7753
Mississippi Relay Services 711
24/7 NurseWise 1-866-912-6285
Dental/Vision 1-866-912-6285

PROVIDERS:

IVR Eligibility Inquiry - Prior Auth 1-866-912-6285
US Script Help Desk 1-800-460-8988
Behavioral Health 1-877-210-8513

Medical claims:

Magnolia
Attn: CLAIMS
PO Box 3090
Farmington, MO 63640-3825

Provider/claims information via the web: www.MagnoliaHealthPlan.com.

<p>Magnolia Address 111 East Capitol Street Suite 500 Jackson, MS 39201</p>

Farmington, MO 63640-3825

Provider/claims information via the web: www.MagnoliaHealthPlan.com.

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 "DentaQuest" and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their 6 digit DentaQuest Location ID, office name and office address. Please refer to your payment remittance or contact DentaQuest's Customer Service Department at 800.235.6147 to obtain your location ID. 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 800.235.6147 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. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:

Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at 800.235.6147.
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 to enter your NPI and the last 4 digits of your **Tax ID number**.
5. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
6. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
7. 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.
8. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.
9. If you choose to make a claim inquiry, you will be transferred to a Customer Service Representative.

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 800.235.6147. They will be able to assist you in utilizing either system.

1.04 Eligibility Verification System (EVS)

800.947.9627

1.05 Facility Authorization Phone Number

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Provider will contact Magnolia Health Plan.

1.06 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Customer Service Department.

2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit “documentation” associated with certain dental services for a Member. Participating Providers will not be paid if this “documentation” is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see section 12). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

Please note that all codes that require authorization can be submitted either prior to the services being performed or retrospectively with the exception of Orthodontic services.

- A. Authorization and documentation submitted before treatment begins (Non-emergency) treatment.

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

Your submission of “documentation” should include:

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

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits A-B) contain a column marked Authorization Required. A “Yes” in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

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

- B. Submitting Authorization Requests and X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the “Learn More” button. To register, click the “Provider Registration” button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)

- Submission of original radiographs with a self addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately and any radiographs received without a SASE will not be returned to the sender.

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

Acceptable methods of mounted radiographs are:

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

Unacceptable methods of mounted radiographs are:

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

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

C. Authorization and documentation submitted with claim (Emergency treatment)

DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied.

D. Authorization for dental treatment of patients with developmental disabilities.

DentaQuest recognizes the additional time that may be required in treatment of patients with developmental disabilities. Standards should allow for up to four (4) visits annually without prior authorization.

DentaQuest will reimburse dentists for the costs of preoperative and postoperative evaluations associated with dental surgery performed on patients with developmental disabilities. Preauthorization shall not be required for dental procedures performed during surgery on these patients for dentally appropriate restorative care provided under general anesthesia. Informed consent, signed by the Member or authorized person, must be obtained prior to the surgical procedure. Provisions should be made to evaluate such procedures as part of a post payment review process.

2.02 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider

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

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

2.03 Electronic Attachments

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

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

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

800.782.5150

2.04 Dispute Resolution /Provider Appeals Procedure

Participating Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This notice *and* additional support information must be sent to DentaQuest within 60 days from the date of the original determination to be reconsidered by DentaQuest's Peer Review Committee.

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

All notices received shall be submitted to DentaQuest's Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider

Provider Appeals

Provider appeals of DentaQuest decisions need to be submitted to DentaQuest. Appeals.

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 800.235.6147. (Policies 200.010, 200.011, 200.013, 200.017)

3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Participating Hospitals are subject to change. You can get find the most current participating hospital listing at www.magnoliahealthplan.com.

- **Biloxi Regional Medical Center (HMA)**
- **Central MS Medical Center (HMA)**
- **Gilmore Memorial Regional Med. Ctr. (HMA)**
- **Madison County Medical Center (HMA)**
- **Natchez Community Hospital (HMA)**
- **Northwest Regional Medical Center (HMA)**
- **Crossgates River Oaks Hospital (HMA)**
- **Riley Hospital (HMA)**
- **River Oaks Hospital (HMA)**
- **Woman's Hospital - River Oaks (HMA)**
- **Wesley Medical Center (CHS)**
- **River Region Medical Center (CHS)**
- **H.C. Watkins Memorial Hospital (Rush)**
- **Laird Hospital (Rush)**
- **Rush Foundation Hospital (Rush)**
- **Scott Regional Hospital (Rush)**
- **North MS Medical Center-Eupora**
- **North MS Medical Center -Iuka**
- **North MS Medical Center -Pontotoc**
- **North MS Medical Center -Tupelo**
- **North MS Medical Center -West Point**
- **Singing River Hospital**
- **Ocean Springs Hospital (Singing River)**
- **Southwest MS Regional Medical Center**
- **Jeff Anderson Regional Medical Center**
- **North Sunflower County Hospital**
- **Lawrence County Hospital**
- **Delta Regional Medical Center**

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- **Jasper General Hospital**
 - **Natchez Regional Medical Center**
 - **Neshoba County Hospital**
 - **North Oak Regional Medical Center**
 - **Quitman County Hospital**

4.00 Claim Submission Procedures (claim filing options)

DentaQuest is committed to processing and paying clean claims within 30 days of receipt. Denied claims will result in written communication to the provider. DentaQuest is able to receive dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website.
- Electronic submission via the clearinghouses
- HIPAA Compliant 837D File.
- Paper claims.

4.01 Submitting Authorization or Claims with X-Rays

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
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- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

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

4.02 Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Provider's Only" 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. Once you have entered the website, click on "DentaQuest", and then click on "For Providers Only." You will then be able to log in using your password and ID. First time users will have to register by utilizing their DentaQuest 6 digit Location ID prior to logging in. Once logged in, select "claim

submission” and choose the Member from the roster you created when checking eligibility. Once you have chosen the Member, you then enter the claim line detail to complete the submission.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations at 888.560.8135 or via e-mail at: operations@DentaQuest.com.

4.03 Electronic Claim Submission via ClearingHouse

In some markets, Dentists may submit their claims to DentaQuest via Affiliated Network Services (ANS). DentaQuest’s current relationship with ANS offers **FREE** transmission for ALL DentaQuest claims. For more information regarding this arrangement, contact ANS at 800.417.6693, extension 234. Additional clearinghouses may be added in the future.

You can contact your software vendor and make certain that they have DentaQuest listed as a payor. 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.

4.04 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will on a case by case basis, work with the Provider to receive their claims electronically via a HIPAA Compliant 837D File from the Provider’s practice management system. Please contact the Systems Operations Department at 888.560.8135 or via e-mail at operations@DentaQuest.com to inquire about this option for electronic claim submission.

4.05 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website <https://nppes.cms.hhs.gov/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) dependant upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group 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.

4.06 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim

form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.

- The 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 date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

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

4.07 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.

4.08 Filing Limits

Claims can be submitted to DentaQuest up to 180 days from the date of service. 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.

4.09 Receipt and Audit of Claims

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

problem. Please contact our Customer Service Department 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.

4.10 Electronic Funds Transfer

As a benefit to participating Providers, DentaQuest offers Electronic Funds Transfer (EFT) 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 EFT Program, Providers must:

- Complete and sign the EFT Authorization Form located on www.dentaquest.com
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the EFT Authorization Form and voided check to DentaQuest.
 - Via Fax – 262.241.4077
 - Via Mail – DentaQuest, LLC.
12121 North Corporate Parkway
Mequon, WI 53092
ATTN: PDA Department

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

Providers enrolled in the EFT 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 EFT 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 EFT 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. Under the Documents header, Select **Remittance Documents**
3. Click on the **View Remittance Documents** button to display the remittance notice
4. Click on the **View** button at the right end of the specific remittance that you would like to view
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-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 800.235.6147 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 Inquiries, Complaints and Grievances (Policies 200.010, 200.011, 200.013, 200.017)

When new Members enroll, Magnolia Health Plan informs the Members of their right to file a complaint, grievance, or appeal. A provider may file a grievance on behalf of the Member, acting as a Member advocate, with the written consent of the Member. Therefore, the provider must be aware of the Member complaint, grievance, and appeal processes, including the timeframes for filing. Complaint and Grievance procedures must comply with Act 68.

DEFINITIONS

Inquiry - Any member's request for administrative service, information or to express an opinion.

Complaint — A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management policies, which has not been resolved and has been filed. Including but not limited to:

- a denial because the requested service/item is not a covered benefit;
- or a failure of the MCO to meet the required time frames for providing a service/item;
- or a failure of the MCO to decide a Complaint or Grievance within the specified time frames;
- or a denial of payment by the MCO after a service has been
- or a denial of payment by the MCO after a service has been delivered because the service/item provided is not a covered service/item for the Member.

The term does not include a Grievance.

Grievance — A request to have the PH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding the PH-MCO decision to:

- deny, in whole or in part, payment for a service/item;
- deny or issue a limited authorization of a requested service/item, including the type or level of service/item;
- reduce, suspend, or terminate a previously authorized service/item;
- deny the requested service/item but approve an alternative service/item.

The term does not include a Complaint.

DPW Fair Hearing — A hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals.

6.01 COMPLAINTS

If an inquiry cannot be resolved to the Member's satisfaction or requires corrective action, the Member or Member's representative, which may include the member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf may file a complaint orally or in writing.

If a Member files a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

The following outlines the process for complaints:

- The Member formally submits a complaint in writing or verbally to Member Services at 1-866-638-1232.
- The Member has at least 45-calendar days to file the complaint from the date of the occurrence of the issue being complained about or the date of the Member's receipt of notice of the plan's decision.
- The Complaints/Grievances Representative receives the complaint and initiates the process for investigation, resolution, analysis, tracking and reporting.
- The Clinical Resource Management Department sends the Member a letter describing the resolution of the complaint within 30 days and explaining the Member's rights to a grievance.

A. First Level Review

- The first level complaint review is completed by an initial review committee, which shall include one or more employees not involved in the initial decision.
- The Member may provide written data or other material in support of the complaint.
- The review and investigation will be completed within 30 days of receipt of the complaint.
- The Member will be informed in writing of the committee's decision within 5 business days of the decision.

B. Second Level Review

- The second level review committee will include three or more individuals who did not participate in the first level review. At least one third of the second level review committee may not be employees of Magnolia Health Plan.
- Magnolia Health Plan shall notify the Member in writing of the right to appear before the second level review committee. In addition, the member shall be notified within 15 days in advance of the date of the review committee meeting.
- The second level review committee shall satisfy the following:
 - Magnolia Health Plan shall provide reasonable flexibility in terms of time and travel distance when scheduling a second level review to facilitate the Member's attendance.
 - If the Member cannot appear in person, Magnolia Health Plan shall provide the Member the opportunity to communicate with the review committee by telephone or other means.
 - Attendance at the second level review shall be limited to Members of the committee, the Member and/or Member's representative, provider or witnesses, and representative of Magnolia Health Plan.
- The decision of the second level review committee shall be binding unless appealed by the Member.
- Testimony taken by the second level Complaint review committee (including the Member's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record. This information is to be forwarded to the Department of Health or the Insurance Department upon appeal to the External Complaint Review.
- Magnolia Health Plan shall complete the second level review within 45 days of the receipt of the Member's request for review.
- Magnolia Health Plan shall notify the Member of the decision of the second level review committee in writing, within 5 business days of the committee's decision.
- The notice shall include the basis of the decision and the procedures and time frame for the Member to file an appeal to the Department of Health or the Insurance Department.

C. Appeal of a Complaint Decision – External Complaint Review

- A Member will have 15 days from receipt of the second level review decision to file an appeal of the decision, in writing, with either the Department of Health or the Insurance Department.
- The appeal shall include the following:
 - Member's name, address and telephone number
 - Identification of Magnolia Health Plan as the plan
 - Member's Magnolia Health Plan Member number
 - Brief description of the issue being appealed.
 - Correspondence from Magnolia Health Plan regarding the second level denial.
- The Department will verify with Magnolia Health Plan that the appeal was submitted within 15 days of the Member's receipt of the notice of the decision by the second level review committee.
- All records from the initial review and second level review will be transmitted to the appropriate department by Magnolia Health Plan within 30 days of the Department's notice to the plan of the complaint appeal. Magnolia Health Plan, provider, and Member may provide additional information for review and consideration.
- The Department and the Insurance Department will determine the appropriate agency for the review.
- The Department may decide to hold an administrative hearing on the appeal. The hearing will be conducted in accordance with the procedures in 1 Pa. Code Part II.
- The Member may be represented by an attorney or other individual before the Department.

D. Expedited Complaint Process

- Magnolia Health Plan must conduct expedited review of a Complaint at any point prior to the second level Complaint decision, if a Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides Magnolia Health Plan with a certification from his or her Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. This certification is necessary even when the Member's request for the expedited review is made orally. The certification must include the Provider's signature.
- A request for an expedited review of a Complaint may be filed either in writing, by fax or orally. Oral requests must be committed to writing by Magnolia Health Plan. The Member's signature is not required.
- Upon receipt of an oral or written request for expedited review, Magnolia Health Plan must inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- If the Provider certification is not included with the request for an expedited review, Magnolia Health Plan, must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. Magnolia Health Plan must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) Business Days of the Member's request for expedited review, Magnolia Health

Plan shall decide the Complaint within the standard timeframes as set forth in this Exhibit. Magnolia Health Plan must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Exhibit GG(6b)).

- If a Member files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- Complaints requiring expedited review must be reviewed by a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review. The members of the Complaint review committee may not have been involved in any previous level of review or decision-making on the issue under review. The licensed physician must decide the Complaint.
- Magnolia Health Plan must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter. In addition, Magnolia Health Plan must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within two (2) days of the decision using the template supplied by the Department (Exhibit GG(6a)).
- Magnolia Health Plan must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
- The Member, or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Complaint review with Magnolia Health Plan within two (2) Business Days from the date the Member receives Magnolia Health Plan's expedited Complaint decision.
- Magnolia Health Plan shall follow Department of Health guidelines relating to submission of requests for expedited external reviews.
- Magnolia Health Plan must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

- The Member may file a request for a DPW Fair Hearing within thirty (30) days from the mail date on the written notice of Magnolia Health Plan's expedited Complaint decision.

6.02 GRIEVANCES

Magnolia Health Plan shall establish, operate and maintain an internal Member grievance system in compliance with sections 2161 and 2162 of the Act (40 P.S. §§ 991.2161 and 991.2162). The Member, or a provider with written consent of the Member, may file a written grievance with Magnolia Health Plan.

A member who has a grievance should contact Customer Services to obtain a formal resolution of their grievance. Each grievance will be promptly investigated. The plan will provide the member with a response to a within thirty (30) days.

During the Appeal process, the member has the right to appoint a person of their choice to assist the member in preparing succinct, factual presentation of the member's complaint to the committee reviewing the appeal. In each step of the appeal process, the member should be as specific as possible as to the solution being sought from the Plan.

If a Member files a Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

A. FIRST-LEVEL GRIEVANCE

A First-Level Grievance can be filed directly and pertains to decisions solely concerning the medical necessity and appropriateness of a Magnolia Health Plan service.

A first-level grievance is filed in one of the following ways:

- A Member requests a grievance independent of filing a complaint
- A provider files a grievance on behalf of the Member
- A Member appeals an adverse decision by filing a first-level grievance (the Member must file within 10 days of receiving written notification to protect service continuation)

If Magnolia Health Plan denies, reduces, or changes the scope of service for a Member, Magnolia Health Plan notifies the Member of the situation in writing and provides information about how to file a grievance and request a DPW fair hearing. To file a grievance or request a hearing, the Member must do so within 30 days of receiving the written notification. An additional 30 days are given for extenuating circumstances.

If the Member chooses to file a first-level grievance:

- The Member must file the first-level grievance verbally or in writing
- The Coordinator of Complaints/Grievances investigates the grievance
- The Member has the right to receive support from a Magnolia Health Plan staff Member who has not been involved in the grievance situation.
- The Review shall be performed by an initial review committee which shall include one or more individuals selected by Magnolia Health Plan. The members of the committee may not have been involved in any prior decisions relating to the grievance. The Committee shall include a licensed

dentist in the same or similar specialty as that which would typically manage or consult on the health care service in question.

- The completion of the review will occur within 30 days of the receipt of request
- Magnolia Health Plan sends the Member a letter with the decision and procedures for appeal within 5 days of the decision

B. EXPEDITED GRIEVANCE

An Expedited Grievance involves care that is alleged to be medically necessary and the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the review process.

The member should notify Customer Services and make a request for an expedited review. In order to request an expedited review, the member may need to provide a written certification from the oral health provider that the member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by a standard appeal process. The certification must include a clinical rationale and facts to support the oral health provider's opinion.

The Plan will arrange to have the Grievance reviewed as expeditiously as the situation requires and no later than the required regulatory timeframe (48 hours) by the Expedited Committee. The committee will include a review by an oral health provider in the same or similar specialty as that which would typically manage or consult on the oral health care service at issue. The member will be informed via a telephone call within 48 hours of the decision and written confirmation will be forwarded to the member.

If the Expedited Committee's decision of the expedited review is adverse to the member, the member may have the option to appeal the decision by requesting an expedited external review. The member will be notified of the right to file such an appeal, if applicable.

If a Member files a Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

The following outlines the process for expedited grievances:

- The Member files the grievance verbally or in writing
- Magnolia Health Plan's Coordinator of Complaints/Grievances investigates the case and submits it to a Medical Director
- The Medical Director reviews the case and renders a written decision to the Member within 48 hours of the Member's request.
- The Member has 2 business days from receipt of the expedited internal review decision to contact Magnolia Health Plan to request and expedited external review.
- Within 1 business day of the Member request, Magnolia Health Plan shall submit a request for an expedited external review to the Department of Health by Fax or telephone call.
- The case will be referred to an external review entity and the Department of Health will assign a certified utilization review entity (CRE) within 1 business day of receipt of the request.

- Magnolia Health Plan will transfer a copy of the case file to the review entity for receipt on the next business day and the CRE has 2 business days to issue a response.
- External expedited review decision may be appealed to a court of competent jurisdiction.

C. SECOND-LEVEL GRIEVANCE

A Second-Level Grievance is an appeal of a first-level grievance decision.

If a Member files a Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

The following is the process for second-level grievances:

- The Member files the grievance verbally or in writing (to protect continuation of services, the Member must file within 45 days of receiving written notification of the first-level or expedited grievance outcome)
- If the Member files the grievance verbally, Magnolia Health Plan will put it in writing
- Magnolia Health Plan offers the Member support through a staff Member not involved in prior decisions
- The second level review committee shall be made up of 3 or more individuals who did not previously participate in the decision to deny coverage or payment for services. The committee must be unbiased in their review and decision.
- Magnolia Health Plan shall notify the Member or Provider in writing of the right to appear before the second level review committee.
- Magnolia Health Plan shall provide reasonable flexibility in terms of time and travel distance when scheduling a second level review to facilitate the Member's attendance.
- If the Member or Provider cannot appear in person the review, Magnolia Health Plan shall provide the Member or Provider the opportunity to participate via telephone. If the Member decides not to attend, it will not affect the decision.
- Attendance at the second review shall be limited to members of the committee, the Member or the Member's representatives or both; the Provider, applicable witnesses and appropriate representative of Magnolia Health Plan. The Committee shall include a licensed dentist in the same or similar specialty as that which would typically manage or consult on the health care service in question.
- The second level review shall be completed within 45 days of receipt of the request for review.
- Magnolia Health Plan sends the Member written notice of the result within five (5) business days of the committee's decision.
- If the grievance is denied, the Member may appeal to DPW.
- Member's can ask for a Fair Hearing at the same time they file a complaint or grievance or Member's can ask for a Fair Hearing after Magnolia Health Plan decides the first level complain or grievance.

6.03 Department of Health External Review Process

Magnolia Health Plan shall establish and maintain an external grievance process by which a Member or Provider with the written consent of the Member, may appeal the denial of a second level grievance following receipt of the second level grievance review decision.

- Member or Provider shall have 15 days from receipt of the second level grievance review decision to file an appeal of the decision with Magnolia Health Plan.
- Within five (5) business days of receipt of the external grievance request, Magnolia Health Plan shall notify the Department of Health the Member or Provider and CRE that conducted the internal grievance review that a request for an external grievance review has been filed.
- Magnolia Health Plan's notification to the Department of Health shall include a request for assignment of a CRE.
- Magnolia Health Plan shall provide the Department of Health with the name, title and phone numbers of both a primary and alternative external grievance coordinator. One of these individuals shall be available to the CRE both for the purpose of performing external grievance reviews and of tracking the status of the reviews.
- The request to the Department of Health shall include the following:
 - Member's name, address and telephone number.
 - If the external grievance is being filed by a Provider, the Provider shall provide both the name of the Member involved and its own identifying information.
 - Name of Member's health plan (Magnolia Health Plan)
 - Magnolia Health Plan identification number
 - Brief description of the issue being appealed
 - The remedy being sought
 - Correspondence from Magnolia Health Plan relating to the matter in question
 - Other reasonably necessary supporting documentation
 - If the external grievance is being requested by a Provider, verifications that Magnolia Health Plan and the Provider have both established escrow accounts in the amount of half the anticipated cost of the review.
- Within 15 days of receipt of the external grievance, Magnolia Health Plan shall forward to the CRE the written documentation regarding the denial including:
 - The decision
 - All reasonably necessary supporting information
 - A summary of applicable issues
 - The contractual language supporting the denial including Magnolia Health Plan's definition of "medical necessity" used in the internal grievance reviews.
- Within the same 15-day period, Magnolia Health Plan shall provide the Member or the Provider with its description of the issue, the remedy being sought by the Member and the list of documents being forwarded to the CRE for the external review.
- Within 2 business days of receiving a request for an external grievance review, the Department of Health will assign a CRE from its list of CRE's on a rotating basis and will provide notice of the assigned CRE to Magnolia Health Plan and CRE.
- Magnolia Health Plan shall notify the Member or Provider with the name, telephone number and address of the CRE assigned within 2 business days of its receipt of the information from the Department.

- The Department of Health will make available additional information from the CRE's accreditation application to Magnolia Health Plan.
- Either party shall have 3 business days from the date of its receipt of the notice of assignment of the CRE to object to the CRE assigned based on conflict of interest, and may request the assignment of another CRE.
- If a party objects, the Department of Health will assign a second CRE. The parties may object to the second CRE.
- If either party objects to the second CRE assigned, the 60-day time period allowed for the CRE's review will be calculated from the date on which both parties accept the CRE.
- The Department of Health will assign a uniform tracking number, which shall be utilized by Magnolia Health Plan, CRE, Member and Provider to communicate with or report data to the Department of Health.
- Magnolia Health Plan shall authorize a health care service and pay a claim determined to be the medically necessary and appropriate by the CRE whether or not Magnolia Health Plan has appealed the CRE's decision to a court of competent jurisdiction.
- If the Provider that filed the external grievance is not the prevailing party, the Provider shall pay the fees and costs associated with the external grievance. If Magnolia Health Plan is not the prevailing party, Magnolia Health Plan shall pay the fees and costs associated with the external grievance review regardless of the identity of the grievant.

6.04 Grievance Reviews by CRE

- The assigned CRE shall review and issue a written decision within 60 days of the filing of the request for an external grievance review request. The decision shall be sent to the Member, Provider, Magnolia Health Plan, and Department of Health.
- The assigned CRE shall review the second level grievance decisions based on whether the health care service denied by the internal review process is medically necessary and appropriate under the terms of the plan.
- The assigned CRE shall receive all information considered by Magnolia Health Plan in reaching any prior decision to deny coverage for the healthcare service in question and information provided under §9.707.
- The assigned CRE's decision shall be made by either of the following:
 - One or more licensed professionals practicing within the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.
 - One or more licensed professionals in active clinical practice or in the same or similar specialty the typically manages or recommends treatment for the health care service being reviewed.
- In reviewing a grievance decision relating to emergency services, the CRE shall utilize the emergency service standards of Act 68 and the definition of "medical necessity" and "emergency" in the Member's certificate of coverage.

6.05 Appeals to the Department of Public Welfare

Magnolia Health Plan Members have the right to request a fair hearing appeal from the Department of Public Welfare (DPW) during any stage of the complaint/grievance process, including after the process if a complaint or grievance is denied. Also, whenever Magnolia Health Plan sends a notice of action regarding the denial, reduction, or change in scope of service for member care, the notice includes information about how to appeal for a DPW fair hearing.

Member's can ask for a Fair Hearing at the same time they file a complaint or grievance or member's can ask for a Fair Hearing after Magnolia Health Plan decides the first level complaint or grievance.

A member who files a request for a DPW Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DPW Fair Hearing, if the request for a DPW Fair Hearing is hand delivered or post-marked within 10 days from the mail date on the written notice of the decision.

The following is the process for a DPW fair hearing appeal:

- The member must file the appeal within 30 days of receiving the written notice of action or within 10 days of receiving written notification from Magnolia Health Plan regarding a denial or reduction in coverage for services
- Members can request assistance from Magnolia Health Plan in filing and preparing the fair hearing appeal
- Members with special needs may be assigned a support person, who helps coordinate the process with Magnolia Health Plan
- Members have the right to be present at the appeal hearing and to bring a family member, friend, lawyer, or other support person
- The member receives written notice of the decision within 30 days
- If the member wishes to appeal the decision, the member can:
 - Send a letter to:
Department of Public Welfare
OMAP-Health Choices Program
P.O. Box 2675
Harrisburg, PA 17105-2675

7.00 Utilization Management Program (Policies 500 Series)

7.01 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. The managed care organizations use this information to create the fee schedules for providers.

7.02 Community Practice Patterns

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

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

7.03 Evaluation

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

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

7.04 Results

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

7.05 Fraud and Abuse (Policies 700 Series)

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

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

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

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

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

8.00 Quality Improvement Program (Policies - 200 Series)

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

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

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 800.235.6147 or via e-mail at: denelig.benefit@DentaQuest.com.

9.00 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 recredentialled at least every 36 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800.235.6147 or via e-mail at: denelig.benefits@DentaQuest.com.

10.00 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:
 - a. Registration data including a complete health history.
 - b. Medical alert predominantly displayed inside chart jacket.
 - c. Initial examination data.
 - d. Radiographs.
 - e. Periodontal and Occlusal status.
 - f. Treatment plan/Alternative treatment plan.
 - g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
 - h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).
2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
 - a. Health history.
 - b. Medical alert.
 - c. Examination/Recall data.
 - d. Periodontal status.
 - e. Treatment plan.
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

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

1. Adequate documentation of registration information which requires entry of these items:
 - a. Patient's first and last name.
 - b. Date of birth.
 - c. Sex.
 - d. Address.
 - e. Telephone number.
 - f. Name and telephone number of the person to contact in case of emergency.
2. An adequate health history that requires documentation of these items:
 - a. Current medical treatment.
 - b. Significant past illnesses.
 - c. Current medications.
 - d. Drug allergies.
 - e. Hematologic disorders.
 - f. Cardiovascular disorders.
 - g. Respiratory disorders.
 - h. Endocrine disorders.

- i. Communicable diseases.
 - j. Neurologic disorders.
 - k. Signature and date by patient.
 - l. Signature and date by reviewing dentist.
 - m. History of alcohol and tobacco usage including smokeless tobacco.
3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
 - a. Significant changes in health status.
 - b. Current medical treatment.
 - c. Current medications.
 - d. Dental problems/concerns.
 - e. Signature and date by reviewing dentist.
4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
 - a. Health problems which contraindicate certain types of dental treatment.
 - b. Health problems that require precautions or pre-medication prior to dental treatment.
 - c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
 - d. Drug sensitivities.
 - e. Infectious diseases that may endanger personnel or other patients.
5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.
 - c. Soft tissue examination.
 - d. Periodontal assessment.
 - e. Occlusal classification.
 - f. Dentition charting.
6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
 - a. Blood pressure. (Recommended)
 - b. Head/neck examination.
 - c. Soft tissue examination.
 - d. Periodontal assessment.
 - e. Dentition charting.
7. Radiographs which are:
 - a. Identified by patient name.
 - b. Dated.
 - c. Designated by patient's left and right side.
 - d. Mounted (if intraoral films).
8. An indication of the patient's clinical problems/diagnosis.
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

-
- a. Procedure.
 - b. Localization (area of mouth, tooth number, surface).
10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
- a. Periodontal pocket depth.
 - b. Furcation involvement.
 - c. Mobility.
 - d. Recession.
 - e. Adequacy of attached gingiva.
 - f. Missing teeth.
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
- a. Gingival status.
 - b. Amount of plaque.
 - c. Amount of calculus.
 - d. Education provided to the patient.
 - e. Patient receptiveness/compliance.
 - f. Recall interval.
 - g. Date.
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
- a. Provider to whom consultation is directed.
 - b. Information/services requested.
 - c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:
 - a. Date of service/procedure.
 - b. Description of service, procedure and observation.
 - c. Type and dosage of anesthetics and medications given or prescribed.
 - d. Localization of procedure/observation. (tooth #, quadrant etc.)
 - e. Signature of the Provider who rendered the service.

 14. Adequate documentation of the specialty care performed by another dentist that includes:
 - a. Patient examination.
 - b. Treatment plan.
 - c. Treatment status.
- C. Compliance
1. The patient record has one explicitly defined format that is currently in use.
 2. There is consistent use of each component of the patient record by all staff.
 3. The components of the record that are required for complete documentation of each patient's status and care are present.
 4. Entries in the records are legible.
 5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

11.00 Patient Recall System Requirements

A. Recall System Requirement

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

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

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

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

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

B. Office Compliance Verification Procedures

- In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- Emergency services must be provided immediately.
- Urgent care must be available within 24 hours.
- Symptomatic acute care must be available within 72 hours.
- The contractor shall bear full responsibility for the provision of emergency dental services, and shall assure the availability of a back-up provider in the event that an on-call provider is unavailable.

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

12.00 Radiology Requirements

Note: Please refer to benefit tables for Radiograph benefit limitations.

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

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal examination with Posterior Bitewings OR a Panoramic Radiograph and Posterior Bitewings, for a new patient with a transitional dentition.

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

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

4. Adult – Dentulous

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

5. Adult – Edentulous

The Panel recommends a Full-Mouth Intraoral Radiographic Survey OR a Panoramic Radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

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

a. Child – Primary and Transitional Dentition

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

b. Adolescent

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

c. Adult – Dentulous

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

d. Adult – Edentulous

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

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

a. Child – Primary Dentition

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

b. Adolescent

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

c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

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

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

4. Growth and Development Assessment

a. Child – Primary Dentition

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

b. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

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

d. Adult

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

13.00 Health Guidelines – Ages 0-18 Years

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

14.00 Clinical Criteria

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

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

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

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

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

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

Criteria

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

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

14.02 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.
- In the event that a crown requires replacement in less than five years, a narrative of medical necessity must be submitted which describes the significant underlying medical and dental condition that will necessitate a replacement less than five years.

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 anterior 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.

14.03 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.

14.04 Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

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 under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

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

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

- Request should include a dated post-endodontic radiograph.

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

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.

Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

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

14.05 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

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

All Operating Room (OR) Cases Must be Authorized.

Provider should submit services to DentaQuest for authorization. Upon receipt from DentaQuest, Provider should contact Health Plan for facility authorization at the number below.

Magnolia Health Plan

866.903.0748

Criteria

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

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.

- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, 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 not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 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.
- Within the first six months following insertion of a new prosthesis, any necessary adjustments, relines, and/or rebases are considered part of the insertion process and are the responsibility of the provider.

Criteria

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

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

- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- In general, a partial denture will be approved for benefits for if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

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 allowed when there are extenuating circumstances, and/or medical necessity.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth 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. In addition, there may be coverage for dentures in cases where extractions are performed in conjunction with an authorized denture or final impression while the member is still eligible.

Continuity of care in cases where the member loses eligibility after extractions are accomplished or impressions taken in conjunction with an authorized denture(s).

- The Health Plan shall honor and pay for plans of care for new Member's and any other on-going services initiated prior to enrollment with the current Health Plan.
- The Health Plan shall use its best efforts to contact the new Member or where applicable, authorized person and/or Health Care manager. However, if after documented, reasonable outreach (i.e., mailers, certified mail, use of MEDM system provided by the state, contact with the Medical Assistance Customer Center (MACC), DDD, or DYFS to confirm to request assistance in locating the Member) the Member fails to respond within 20 working days of certified mail, the Health Plan may cease paying for the pre-existing service until the Member, or where applicable, authorized person, contacts the Health Plan for re-evaluation.
- For MCSA Member's, the Health Plan shall case manage these services.
- With respect to former Plan A parent/caregiver relatives with a program status code of 380 who are transferred to Plan D, the Health Plan shall continue to provide dental services to completion that have been approved or initiated under the Health Plan.
- If the Member has already had a dental treatment procedure initiated prior to his/her enrollment in the current Health Plan, the initiating treating provider must complete that procedure (not the entire treatment plan).

14.07 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 lateral exostosis (es) to be removed.

14.08 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.

14.09 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.

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization.

Documentation needed for authorization of any periodontal procedures:

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

Periodontal scaling and root planing (D4341), 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) affected teeth 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.
- Other periodontal procedures will be reviewed for medical necessity and appropriateness of care according to the ADA definitions of code terminology.

Attachments

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 of Mississippi, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
 - a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Mississippi or its regulatory agencies or Plan and DentaQuest (a "Medicaid 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 of Mississippi.
- E. "Medically Necessary" means a service or benefit is medically necessary if it is compensable under the Medicaid Program and if it meets any one of the following standards:
- 1) The Service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
 - 2) The service or benefit will, or is reasonably expected to, reduce or ameliorate, the physical, mental, or developmental effects of an illness, condition, injury or disability.
 - 3) The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
- F. Member – Any individual who is enrolled with Magnolia Health Plan under the HealthChoices program and for who Magnolia Health Plan has agreed to arrange the provision of Physical Health Services under the provisions of the HealthChoices Program.
- 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.

DentaQuest, LLC

- 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.

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:

- Orthodontic Criteria Index Form – Comprehensive D8080
- Malocclusion Severity Assessment (Salzmann)
- Malocclusion Severity Assessment (Salzmann) Instructions
- Orthodontic Continuation of Care Form
- OrthoCAD Submission Form
- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Electronic Funds Transfer Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- HIPAA Companion Guide

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 800-235-6147.

Covered Benefits (See Exhibits A-B)

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

800-235-6147, press option 2

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

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

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

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

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

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

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

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

DentaQuest Authorization Process

IMPORTANT

For procedures where “Authorization Required” fields indicate **“yes”**.

Please review the information below on when to submit documentation to DentaQuest. The information refers to the “Documentation Required” field in the Benefits Covered section (Exhibits A-B). In this section, documentation may be requested to be sent prior to beginning treatment or “with claim” after completion of treatment with the exception of Orthodontics.

When documentation is requested:

“Authorization Required” Field	“Documentation Required” Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation Requested	Emergency	Send documentation with claim after treatment

When documentation is requested “with claim”:

“Authorization Required” Field	“Documentation Required” Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

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

Members have a yearly maximum of \$2,500.

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

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

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

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation-problem focused	0-20		No	Four of (D0140) per 12 Month(s) Per patient.	
D0145	oral evaluation under 3 years of age	0-3		No	One of (D0145) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation	0-20		No	Two of (D0150) per 12 Month(s) Per patient.	
D0210	intraoral-complete series (including bitewings)	0-20		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	0-20		No		
D0230	intraoral-periapical-each additional film	0-20		No		
D0270	bitewing - single film	0-20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient.	
D0272	bitewings - two films	0-20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient.	
D0273	bitewing - three films	0-20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient.	
D0274	bitewings - four films	0-20		No	One of (D0270, D0272, D0273, D0274) per 6 Month(s) Per patient.	

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0321	other temporomandibular joint films, by report	0-20		Yes		narrative of medical necessity
D0330	panoramic film	0-20		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0340	cephalometric film	0-20		No	One of (D0340) per 24 Month(s) Per patient. Ortho only.	
D0350	oral/facial images	0-20		No	One of (D0350) per 24 Month(s) Per patient. Ortho only.	
D0470	diagnostic casts	0-20		No	Ortho only.	
D0999	unspecified diagnostic procedure, by report	0-20		Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	0-20		No	Two of (D1120) per 12 Month(s) Per patient.	
D1203	topical application of fluoride (prophylaxis not included) - child	0-20		No	Two of (D1203, D1206) per 12 Month(s) Per patient.	
D1206	topical fluoride varnish	0-20		No	Two of (D1203, D1206) per 12 Month(s) Per patient.	
D1351	sealant - per tooth	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 60 Month(s) Per patient.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient.	
D1515	space maint-fixed-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515, D1525) per 24 Month(s) Per patient.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515, D1525) per 24 Month(s) Per patient.	
D1550	recementation space maintainer	0-20		No	Not covered within 6 months of placement.	
D1555	removal of fixed space maintainer	0-20		No	Not allowed by the same provider who placed appliance.	

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Reimbursement includes local anesthesia.

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140) per 36 Month(s) Per patient.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2150) per 36 Month(s) Per patient.	
D2160	Amalgam - three surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2160) per 36 Month(s) Per patient.	
D2161	Amalgam - four surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2161) per 36 Month(s) Per patient.	
D2330	resin-1 surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2330) per 36 Month(s) Per patient.	
D2331	resin-2 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2331) per 36 Month(s) Per patient.	
D2332	resin-3 surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2332) per 36 Month(s) Per patient.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2335) per 36 Month(s) Per patient.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 36 Month(s) Per patient.	
D2391	resin-based composite - 1 surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2391) per 36 Month(s) Per patient.	
D2392	resin-based composite - 2 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2392) per 36 Month(s) Per patient.	
D2393	resin-based composite - 3 surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2393) per 36 Month(s) Per patient.	
D2394	resin-based composite - 4 or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2394) per 36 Month(s) Per patient.	
D2750	crown-porcelain fused to high noble	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2750) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D2751	crown-porcelain fused to metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2751) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D2752	crown-porcelain fused noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D2752) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930) per 36 Month(s) Per patient.	

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 1 - 32	No	One of (D2931) per 60 Month(s) Per patient.	
D2933	prefabricated steel crown with resin window	0-20	Teeth 1 - 32, A - T	No	One of (D2933) per 36 Month(s) Per patient.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	One of (D2934) per 36 Month(s) Per patient.	
D2940	sedative filling	0-20	Teeth 1 - 32, A - T	No		
D2952	cast post and core in addition to crown	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D2999	unspecified restorative procedure, by report	0-20	Teeth 1 - 32, A - T	Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

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

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

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

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration)	0-20	Teeth 2 - 15, 18 - 31, A - T	No		
D3222	partial pulpotomy for apexogenesis	0-20		No		
D3310	Endodontic therapy, anterior (exc final rest)	0-20	Teeth 6 - 11, 22 - 27	No		
D3320	Endodontic therapy, bicuspid (exc final restore)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No		
D3330	Endodontic therapy, molar(excluding final restore)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No		
D3999	unspecified endodontic procedure, by report	0-20	Teeth 1 - 32, A - T	Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Dental codes listed in this section, with "yes" in the "Authorization Required" section may be submitted prior to treatment or for retrospective pre-payment review with proper documentation.

For medical codes listed in this section with "yes" in the "Authorization Required" section:

Services that require prior authorization as noted in the "Documentation Required" section must be received with appropriate documentation no less than 15 days prior to the date of treatment. Failure to obtain prior authorization will result in denial of claim payment. Failure to submit the prior authorization request in a timely manner will require rescheduling to meet this time frame requirement.

Emergency prior authorization requests will be handled for unique situations. Supporting documentation must be submitted. Failure to submit supporting documentation and/or failure to qualify as a true emergency will result in denial of the prior authorization as well as claim payment.

Services that indicate "Yes" in the Authorization Required column but that do NOT indicate "Requires Prior Authorization" in the Documentation Required column will be reviewed for medical necessity prior to reimbursement for the procedure. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the Documentation Required column) with the claim form.

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4211	gingivectomy or gingivoplasty, per tooth	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4211) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4240	gingival flap procedure, including root planing - per quadrant	10 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4241	gingival flap procedure, including root planing - 1-3 teeth, per quadrant	10 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4241) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4260	osseous surgery (including flap entry and closure) - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4261	osseous surgery (including flap entry and closure) - 1-3 teeth, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4261) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4341	periodontal scaling and root planing, per quadrant	10 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341) per 12 Month(s) Per patient.	pre-operative x-ray(s)
D4342	periodontal scaling and root planing - 1-3 teeth, per quadrant	10 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4342) per 12 Month(s) Per patient.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

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

Authorization for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Partial dentures are not a covered benefit when 8 or more posterior teeth are in occlusion.

Dentures will not be preauthorized when:

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

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

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20		Yes	One of (D5110) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-20		Yes	One of (D5120) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture-resin base	0-20		Yes	One of (D5211) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5212	mandibular partial denture-resin base	0-20		Yes	One of (D5212) per 60 Month(s) Per patient.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5955	palatal lift prosthesis, definitive	0-20		Yes	One of (D5955) per 60 Month(s) Per patient.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6999	fixed prosthodontic procedure	0-20	Teeth 5 - 12, 21 - 28	No		

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Reimbursement includes local anesthesia and routine post-operative care.

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

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction - erupted or exposed root	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal erupted tooth requiring elevation of mucoperiosteal flap	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7250	surgical removal of residual tooth roots	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7260	oroantral fistula closure	0-20		No		
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	No		
D7272	tooth transplantation (includes reimplantation from one site to another)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7285	biopsy of oral tissue - hard (bone, tooth)	0-20		Yes		pre-operative x-ray(s)
D7286	biopsy of oral tissue - soft (all others)	0-20		Yes		pre-operative x-ray(s)
D7288	brush biopsy - transepithelial sample collection	0-20		Yes		pre-operative x-ray(s)
D7290	surgical repositioning of teeth	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D7310	alveoloplasty in conjunction with extractions per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narrative of medical necessity
D7350	vestibuloplasty - ridge extension	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7410	radical excision - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	0-20		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-20		Yes		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7465	destruction of lesion(s) by physical or chemical method, by report	0-20		Yes		narrative of medical necessity
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7490	radical resection of mandible with bone graft	0-20		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, A - T	No		
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		No		
D7530	removal of foreign body, skin, or subcutaneous alveolar tissue	0-20		Yes		narrative of medical necessity
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7550	sequestrectomy for osteomyelitis	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narrative of medical necessity
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	0-20		Yes		narrative of medical necessity
D7610	maxilla - open reduction	0-20		Yes		narrative of medical necessity
D7620	maxilla - closed reduction	0-20		Yes		narrative of medical necessity
D7630	mandible-open reduction	0-20		Yes		narrative of medical necessity
D7640	mandible - closed reduction	0-20		Yes		narrative of medical necessity
D7650	malar and/or zygomatic arch-open reduction	0-20		Yes		narrative of medical necessity
D7660	malar and/or zygomatic arch-closed	0-20		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes		narrative of medical necessity
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes		narrative of medical necessity
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		Yes		narrative of medical necessity
D7710	maxilla - open reduction	0-20		Yes		narrative of medical necessity
D7720	maxilla - closed reduction	0-20		Yes		narrative of medical necessity
D7730	mandible - open reduction	0-20		Yes		narrative of medical necessity
D7740	mandible - closed reduction	0-20		Yes		narrative of medical necessity
D7750	malar and/or zygomatic arch-open reduction	0-20		Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7760	malar and/or zygomatic arch-closed reduction	0-20		Yes		narrative of medical necessity
D7770	alveolus-stabilization of teeth, open reduction splinting	0-20		Yes		narrative of medical necessity
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		Yes		narrative of medical necessity
D7810	open reduction of dislocation	0-20		Yes		narrative of medical necessity
D7820	closed reduction dislocation	0-20		Yes		narrative of medical necessity
D7830	manipulation under anesthesia	0-20		Yes		narrative of medical necessity
D7840	condylectomy	0-20		Yes		narrative of medical necessity
D7850	surgical discectomy, with/without implant	0-20		Yes		narrative of medical necessity
D7860	arthrotomy	0-20		Yes		narrative of medical necessity
D7870	arthrocentesis	0-20		Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	0-20		Yes		narrative of medical necessity
D7911	complicated suture-up to 5 cm	0-20		Yes		narrative of medical necessity
D7912	complex suture - greater than 5cm	0-20		Yes		narrative of medical necessity
D7920	skin graft (identify defect covered, location and type of graft)	0-20		Yes		narrative of medical necessity
D7940	osteoplasty- for orthognathic deformities	0-20		Yes		narrative of medical necessity
D7941	osteotomy - madibular rami	0-20		Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7943	osteotomy- mandibular rami with bone graft; includes obtaining the graft	0-20		Yes		narrative of medical necessity
D7944	osteotomy - segmented or subapical - per sextant or quadrant	0-20		Yes		narrative of medical necessity
D7945	osteotomy - body of mandible	0-20		Yes		narrative of medical necessity
D7946	LeFort I (maxilla - total)	0-20		Yes		
D7947	LeFort I (maxilla - segmented)	0-20		Yes		narrative of medical necessity
D7948	LeFort II or LeFort III - without bone graft	0-20		Yes		narrative of medical necessity
D7949	LeFort II or LeFort III - with bone graft	0-20		Yes		narrative of medical necessity
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones	0-20		Yes		narrative of medical necessity
D7955	repair of maxillofacial soft and hard tissue defect	0-20		Yes		narrative of medical necessity
D7960	frenulectomy-separate procedure	0-20		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7980	sialolithotomy	0-20		Yes		narrative of medical necessity
D7981	excision of salivary gland, by report	0-20		Yes		narrative of medical necessity
D7982	sialodochoplasty	0-20		Yes		narrative of medical necessity
D7983	closure of salivary fistula	0-20		Yes		narrative of medical necessity
D7990	emergency tracheotomy	0-20		Yes		narrative of medical necessity
D7991	coronoidectomy	0-20		Yes		narrative of medical necessity

Exhibit A Benefits Covered for MS Magnolia Child Medicaid

Medicaid Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.

Since a case must be dysfunctional to be accepted for treatment, Members whose molars and bicuspid are in good occlusion seldom qualify. Crowding alone is not usually dysfunctional in spite of the aesthetic considerations.

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

OrthoCad electronic equivalent, panorex & cephalometric radiographs, extraoral and intraoral photos, and diagnosis/treatment plan must be submitted with the request for prior authorization of services. Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Orthodontists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member or face possible termination of their Provider agreement. Providers cannot bill prior to services being performed.

If the case is denied, the prior authorization will be returned to the Provider indicating that DentaQuest will not cover the orthodontic treatment. However, an authorization will be issued for the payment of the pre-orthodontic visit (code D8660), which includes treatment plan, radiographs, and/or photos, records and diagnostic models, for full treatment cases only (D8080), at the Provider's contracted rate. This payment will be automatically generated for any case denied for full treatment.

General Billing Information for Orthodontics:

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

If a Member becomes ineligible during treatment and before full payment is made, it is the Member's responsibility to pay the balance for any remaining treatment. The Provider should notify the Member, in writing, of this requirement prior to beginning treatment.

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

Electronically file, fax or mail a copy of our the completed ADA form with the date of service (banding date) filled in. Our fax number is 262. 241.7150.

Initial payments for orthodontics (code D8080) includes pre-orthodontic visit, radiographs, treatment plan, records, diagnostic models, initial banding, debanding, 1 set of retainers, and 24 months of retainer adjustments (If retainer fees are not separate).

Once DentaQuest receives the banding date, the initial payment for code D8080 will be set to pay out. Providers must submit claims for periodic treatment visits (Code D8670). The member must be eligible on the date of the visit.

The maximum case payment for orthodontic treatment will be 1 initial payment (D8080) and 24 periodic orthodontic treatment visits (D8670). Additional periodic orthodontic treatment visits beyond 24 will be the Provider's financial responsibility and not the Member's. Members may not be billed for broken, repaired, or replacement of brackets or wires.

The Member must be eligible with their Health Plan in order for payments to be made. Whenever the Member becomes ineligible, the Member is responsible for payment during that time period.

Payment of records for cases that are denied will be made automatically. There is no need to submit for the records payment (Code D8660). Payment of records/exams (Code D8660) will NOT be paid prior to the case being reviewed by the consultant. Please do not submit separate claims for these procedures.

Please notify DentaQuest should the Member discontinue treatment for any reason

Continuation of Treatment:

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

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

It is the Provider's and Member's responsibility to get the required information. Cases cannot be set-up for possible payment without complete information.

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes		Study model or OrthoCad, x-rays
D8670	periodic orthodontic treatment visit (as part of contract)	0-20		Yes	Twenty-Four of (D8670) per 1 Lifetime Per patient. Maximum of 24 visits reimbursed.	Study model or OrthoCad, x-rays
D8999	unspecified orthodontic procedure, by report	0-20		Yes		narrative of medical necessity

**Exhibit A Benefits Covered for
MS Magnolia Child Medicaid**

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No		
D9310	consultation	0-20		No		
D9940	occlusal guard, by report	0-20		Yes		narrative of medical necessity
D9999	unspecified adjunctive procedure, by report	0-20		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

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

Members have a yearly maximum of \$2,500.

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

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

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

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation-problem focused	21 and older		No	Four of (D0140) per 12 Month(s) Per patient.	
D0210	intraoral-complete series (including bitewings)	21 and older		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0220	intraoral-periapical-1st film	21 and older		No		
D0230	intraoral-periapical-each additional film	21 and older		No		
D0270	bitewing - single film	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two films	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewing - three films	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four films	21 and older		No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0321	other temporomandibular joint films, by report	21 and older		Yes	Two of (D0321) per 12 Month(s) Per patient.	narrative of medical necessity
D0330	panoramic film	21 and older		No	One of (D0210, D0330) per 24 Month(s) Per patient.	

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0999	unspecified diagnostic procedure, by report	21 and older		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Dental codes listed in this section, with "yes" in the "Authorization Required" section may be submitted prior to treatment or for retrospective pre-payment review with proper documentation.

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty, per tooth	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including flap entry and closure) - per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including flap entry and closure) - 1-3 teeth, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Reimbursement includes local anesthesia and routine post-operative care.

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

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction - erupted or exposed root	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal erupted tooth requiring elevation of mucoperiosteal flap	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-op x-ray(s), perio charting
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-op x-ray(s), perio charting

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7250	surgical removal of residual tooth roots	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes		pre-op x-ray(s), perio charting
D7260	oroantral fistula closure	21 and older		Yes		pre-op x-ray(s), perio charting
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D7285	biopsy of oral tissue - hard (bone, tooth)	21 and older		Yes		Pathology report
D7286	biopsy of oral tissue - soft (all others)	21 and older		Yes		Pathology report
D7288	brush biopsy - transepithelial sample collection	21 and older		Yes		Pathology report
D7290	surgical repositioning of teeth	21 and older	Teeth 1 - 32	Yes		Pathology report
D7310	alveoplasty in conjunction with extractions per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		Pathology report
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-ray(s), perio charting
D7320	alveoplasty not in conjunction with extractions - per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-ray(s), perio charting
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-ray(s), perio charting
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-ray(s), perio charting
D7350	vestibuloplasty - ridge extension	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-ray(s), perio charting
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	21 and older		Yes		Pathology report

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	21 and older		Yes		Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7465	destruction of lesion(s) by physical or chemical method, by report	21 and older		Yes		narrative of medical necessity
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7490	radical resection of mandible with bone graft	21 and older		Yes		narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, A - T	No		
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No		
D7530	removal of foreign body, skin, or subcutaneous alveolar tissue	21 and older		Yes		narrative of medical necessity
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		Yes		narrative of medical necessity
D7550	sequestrectomy for osteomyelitis	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narrative of medical necessity
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	21 and older		Yes		narrative of medical necessity
D7610	maxilla - open reduction	21 and older		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7620	maxilla - closed reduction	21 and older		Yes		narrative of medical necessity
D7630	mandible-open reduction	21 and older		Yes		narrative of medical necessity
D7640	mandible - closed reduction	21 and older		Yes		narrative of medical necessity
D7650	malar and/or zygomatic arch-open reduction	21 and older		Yes		narrative of medical necessity
D7660	malar and/or zygomatic arch-closed	21 and older		Yes		narrative of medical necessity
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		Yes		narrative of medical necessity
D7671	alveolus - open reduction, may include stabilization of teeth	21 and older		Yes		narrative of medical necessity
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	21 and older		Yes		narrative of medical necessity
D7710	maxilla - open reduction	21 and older		Yes		narrative of medical necessity
D7720	maxilla - closed reduction	21 and older		Yes		narrative of medical necessity
D7730	mandible - open reduction	21 and older		Yes		narrative of medical necessity
D7740	mandible - closed reduction	21 and older		Yes		narrative of medical necessity
D7750	malar and/or zygomatic arch-open reduction	21 and older		Yes		narrative of medical necessity
D7760	malar and/or zygomatic arch-closed reduction	21 and older		Yes		narrative of medical necessity
D7770	alveolus-stabilization of teeth, open reduction splinting	21 and older		Yes		narrative of medical necessity
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	21 and older		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7810	open reduction of dislocation	21 and older		Yes		narrative of medical necessity
D7820	closed reduction dislocation	21 and older		Yes		narrative of medical necessity
D7830	manipulation under anesthesia	21 and older		Yes		narrative of medical necessity
D7840	condylectomy	21 and older		Yes		narrative of medical necessity
D7850	surgical discectomy, with/without implant	21 and older		Yes		narrative of medical necessity
D7860	arthrotomy	21 and older		Yes		narrative of medical necessity
D7870	arthrocentesis	21 and older		Yes		narrative of medical necessity
D7910	suture small wounds up to 5 cm	21 and older		Yes		narrative of medical necessity
D7911	complicated suture-up to 5 cm	21 and older		Yes		narrative of medical necessity
D7912	complex suture - greater than 5cm	21 and older		Yes		narrative of medical necessity
D7920	skin graft (identify defect covered, location and type of graft)	21 and older		Yes		narrative of medical necessity
D7940	osteoplasty- for orthognathic deformities	21 and older		Yes		narrative of medical necessity
D7941	osteotomy - madibular rami	21 and older		Yes		narrative of medical necessity
D7943	osteotomy- mandibular rami with bone graft; includes obtaining the graft	21 and older		Yes		narrative of medical necessity
D7944	osteotomy - segmented or subapical per sextant or quadrant	21 and older		Yes		narrative of medical necessity
D7945	osteotomy - body of mandible	21 and older		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7946	LeFort I (maxilla - total)	21 and older		Yes		narrative of medical necessity
D7947	LeFort I (maxilla - segmented)	21 and older		Yes		narrative of medical necessity
D7948	LeFort II or LeFort III - without bone graft	21 and older		Yes		narrative of medical necessity
D7949	LeFort II or LeFort III - with bone graft	21 and older		Yes		narrative of medical necessity
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones	21 and older		Yes		narrative of medical necessity
D7955	repair of maxillofacial soft and hard tissue defect	21 and older		No		narrative of medical necessity
D7960	frenulectomy-separate procedure	21 and older		Yes		narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7980	sialolithotomy	21 and older		Yes		narrative of medical necessity
D7981	excision of salivary gland, by report	21 and older		Yes		narrative of medical necessity
D7982	sialodochoplasty	21 and older		Yes		narrative of medical necessity
D7983	closure of salivary fistula	21 and older		Yes		narrative of medical necessity
D7990	emergency tracheotomy	21 and older		Yes		narrative of medical necessity
D7991	coronoidectomy	21 and older		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for
MS Magnolia Adult Medicaid**

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No		narrative of medical necessity
D9310	consultation	21 and older		No		
D9999	unspecified adjunctive procedure, by report	21 and older		No		narrative of medical necessity