Doral Dental Services of Illinois, LLC

Effective July 1, 2009

Dental Office Reference Manual

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Mequon, WI 53092
888.281.2076
Fax 262.241.7401
www.doralusa.com

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Doral Dental Services of Illinois, LLC
Address and Telephone Numbers

Doral Dental Services of Illinois, LLC

Customer Service
(For HFS Beneficiaries)
12121 North Corporate Parkway
Mequon, WI 53092
1.888.286.2447
Fax: 262.834.3450
TTY (Hearing Impaired) 1.800.466.7566

Information Systems
12121 North Corporate Parkway
Mequon, WI 53092
1.888.875.7482

Prior Authorization/Retrospective Review
12121 North Corporate Parkway
Mequon, WI 53092
1.888.875.7482
Fax: 262.241.7150
Email: ddusa_um@doralusa.com

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

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

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

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

Provider Relations (Claims Questions)
12121 North Corporate Parkway
Mequon, WI 53092
1.888.875.7482
Fax: 262.241.7379
Email: denclaims@doralusa.com

IL Department of Healthcare and Family Services (HFS)

Dental Program Manager
607 East Adams, 4th Floor
Springfield, IL 62701
1.217.557.5438

HFS Provider Hotline
1.800.842.1461

HFS Beneficiary Hotline
1.800.226.0768

TTY (Hearing Impaired) Hotline
1.877.204.1012

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

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

Fraud Hotline
1.800.252.8903

TTY (Hearing Impaired) Fraud Hotline
1.800.447.6404

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

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Doral Dental Services of Illinois, LLC

Statement of Beneficiary Rights and Responsibilities

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

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

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

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

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

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

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

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

Likewise:

1. All Beneficiaries have the responsibility to provide, to the best of their abilities, accurate information that Doral Dental and its participating dentists need in order to provide the highest quality of health care services.

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

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

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Doral Dental Services of Illinois, LLC

Statement of Provider Rights and Responsibilities

Enrolled Participating Providers shall have the right to:

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

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

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

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

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

Likewise:

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

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

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

* * *

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

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Dental Office Reference Manual

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1.00 Beneficiary Eligibility Verification Procedures and Services to Beneficiaries

1.01 Beneficiary Eligibility Card

HFS Beneficiaries are issued eligibility cards monthly.

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

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

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

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

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

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

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

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

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

See **Attachment B** for a copy of the card and an explanation of the information contained on the card. For additional information concerning Beneficiary Eligibility Cards, please contact Doral's Provider Relations Department at 1.888.875.7482.

1.02 Handbook for Providers of Medical Services

The Department's *Handbook for Providers of Medical Services* is available for your review
at http://www.hfs.illinois.gov/handbooks/ .Please refer to Chapter 100 (General Policy and Procedures), for information necessary for providers to receive payment from the

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Department. If you do not have access to the Internet, please call 217.782.0538 or 217.524.7306 to request a copy of the handbook.

1.03 Doral Eligibility Systems

Enrolled Participating Providers may access Beneficiary eligibility information through:

1) Doral's Interactive Voice Response (IVR) system (eligibility hotline at 888.875.7482)
2) the "Providers Only" section of Doral's website at www.doralusa.com
3) Affiliated Network Services' (ANS) website at www.ANSlink.net
4) Doral's Customer Service Department at 888.281.2076

The eligibility information received from any of the above sources is the same information you receive by calling Doral's Customer Service Department; however, by utilizing another source, you are able to get eligibility 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 IVR line

To access the IVR, simply call Doral's Customer Service Department at 888.875.7482 and press 1 for eligibility. The IVR system is able to answer all of your eligibility questions for as many Beneficiaries as you wish to check. Using your telephone keypad, you can request eligibility information on a HFS Beneficiary by entering your 6 digit Doral location number, the Beneficiary's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below.

Directions for using Doral's IVR to verify eligibility:

1. Call Doral Customer Service at 888.875.7482.
2. When prompted, press 1 to select eligibility verification.
3. When prompted, enter your 6 digit **Doral Location ID**.
4. When prompted, enter the Beneficiary's ID, less any alpha characters that may be part of the ID.
5. When prompted, enter an expected date of service in DDMMYYYY format.
6. Upon system verification of the Beneficiary's eligibility for the date of service you entered, you will be prompted to verify the eligibility of another Beneficiary, make a claim inquiry or make a benefit inquiry.
7. If you choose to verify the eligibility of an additional Beneficiary(s), you will be asked to repeat steps 4 and 5 above for each Beneficiary.
8. If you choose to make a claim or benefit inquiry, you will be transferred to a Customer Service Representative.

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

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Access to eligibility information via www.doralusa.com

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

To access the eligibility information via Doral's website, simply log on to the website at www.doralusa.com Once you have entered the website, click on "Doral Dental USA" and then click on "For Providers Only." You will then log in using your password and ID. First time users will have to register by utilizing their 6 digit Doral Location ID, office name and office address. Please refer to your payment remittance or contact Doral's Customer Service Department at 888.875.7482 to obtain your location ID. Once logged in, select "eligibility look up" and enter the applicable information for each Beneficiary you are inquiring about. You are able to check on an unlimited number of Beneficiaries and can print the summary of eligibility given by the system for your records.

Access to eligibility information via www.ANSlink.net

Enrolled Participating Providers may also verify Beneficiary eligibility via Affiliated Network Services' website at www.ANSlink.net. You can verify the Beneficiary's eligibility on-line by entering the Beneficiary's date of birth, the expected date of service and the Beneficiary's identification number or last name and first initial. When online, type www.ANSlink.net into the web browser. This will take you to the screen that allows you to enter the ANSLink® system. After pressing the enter button, the log-in screen will appear. If the office signing-in has a user ID and password, that information is entered in the appropriate spaces. If it is the first time for an office using the system, the "NEW OFFICE" button is selected, taking the user through a step-by-step registration process to gain access into ANSLink®.

If you have questions on verifying eligibility via the ANS website, please contact ANS at 800.417.6693, extension 234, or via e-mail at:

info@affnetserv.com

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 websites, please contact the Customer Service Department at 888.875.7482. They will be able to assist you in utilizing either system.

1.04 All Kids/HFS Dental Program Copayments

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

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

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

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

1.05 Expanded Dental Services for Certain Beneficiaries

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

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

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

The DHS Local Office Administrator makes the decision to approve or deny the dental services. The Beneficiary and the dentist are notified of the decision (Form 1934).

Once the dental work has been completed, the dentist bills the local DHS office at the address listed on the approval memo and includes the approval forms with the dentist's statement.

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

1.06 Transportation Benefits for Certain Beneficiaries

Members who need assistance with transportation should contact Doral's Customer Service Department directly at 888.286.2447.

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

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

Please note: If a Beneficiary is seeing a specialist and he/she needs transportation, the Beneficiary must have a written referral from a general dentist. There are **no specific**

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forms. The general dentist may simply provide a notation of treatment required on office letterhead. This written referral is required by HFS' transportation vendor and HFS in order for the Beneficiary to receive transportation to go to the specialist.

1.07 Consent Process for DCFS Wards

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

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

If a DCFS ward arrives for dental care on a weekday (between 8:30 AM and 5:00 PM) and you do not have a consent, please contact the DCFS Consent Unit at 800.828.2179 for assistance. The DCFS Consent Unit can facilitate your obtaining a consent so that the appointment does not need to be rescheduled. If urgent treatment is required during weekends, holidays and after regular office hours, please call DCFS at 773.989.3450 or 217.782.6533 to obtain a consent.

1.08 HFS Dental Program Brochures

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

www.doralusa.com.

Doral provides outreach to families of children who have not received a dental service within the last 12 months of enrollment. Dentists needing assistance in Beneficiary follow-up may contact Doral at 888.281.2076.

1.09 Doral Customer Service Numbers

Doral offers Customer Service for Providers at **888.281.2076**.

Doral offers Customer Service for Beneficiaries at **888.286.2447**.

Doral offers TTY service for hearing impaired Beneficiaries at **800.466.7566**.

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2.00 Covered Benefits

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

Coverage	Attachment
Children	**AA**
Adult	**BB**

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

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

Missed Appointments

If your office mails letters to Beneficiaries who miss appointments, the following language may be helpful to include:

- "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."

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

- Contact the Beneficiary by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through another state agency such as DCFS, DSCC or DHS, contact staff from that program to ensure the scheduled appointment is kept.

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

If an HFS Beneficiary exceeds your office policy for missed appointments, you may choose to terminate the Beneficiary from your practice. Notify the Beneficiary of your decision and encourage him/her to contact Doral at 888.286.2447 for a referral to a new dentist.

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

888.281.2076

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Doral recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 7 years, and records pertaining to the most recent 12 months must be available on-site.

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

For reimbursement, Enrolled Participating Providers should bill only per unique surface regardless of locations. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA procedure code D2140. Furthermore, Doral 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).

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

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

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

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

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

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

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2.01 Payment for Non-Covered Services

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

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

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

2.02 Electronic Attachments

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

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

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at 800.782.5150.

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

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

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3.00 Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

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

Doral utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. Doral's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Sections 13 and 14). Please review these criteria as well as the Benefits covered to understand the decision-making process used to determine payment for services rendered.

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

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

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

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

Within fourteen (14) days of receipt of a prior authorization or a retrospective review request, that in the opinion of Doral requires additional information, Doral will notify the provider submitting the request that additional information is necessary. **Doral must receive information/documentation sufficient to show necessity in order to approve a prior authorization or a retrospective review.** The additional information sought may include, but is not limited to additional Beneficiary/patient information, additional procedure information or additional diagnostic information necessary to process or review the prior authorization.

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

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

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Retrospective Review

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

After the Doral Consultant reviews the documentation, an authorization number is provided to the submitting office for tracking purposes and to maintain in the Beneficiary's record. **This authorization number is normally provided within ten business days from the date the documentation is received.**

For emergency services submitted for retrospective review, an authorization number is assigned, and the claim is forwarded for processing. **The office will receive a Prior Authorization Determination document, but no further submission is necessary for payment.**

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4.00 Dental Services in a Hospital Setting

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

Patient Criteria

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

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

Dental Billing Procedures

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

  Doral Dental Services of IL, LLC.
  Attn. Hospital Claims
  PO Box 339
  Mequon, WI 53092

Hospital/ASTC Billing Procedures

The hospital or ASTC will bill HFS on a UB-92 form for the all-inclusive rate for facility services using the assigned CDT/HCPCS dental code. The hospital must have this code in order to be paid for the facility services. The applicable dental codes will result in payment to hospital/ASTC for the Ambulatory Procedures Listing (APL) Group 1d – Surgical Procedures/Very Low Intensity. All facility bills for services performed in the outpatient setting should be forwarded to:

Department of Healthcare and Family Services
P.O. Box 19132
Springfield, Illinois 62763

Participating Hospitals/ASTCs

Dentists must administer the services at a hospital or ASTC that is enrolled in the Illinois HFS Medical Benefits Program. Questions regarding hospital participation should be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

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5.00 Claim Submission Procedures

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

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

5.01 Electronic Claim Submission Utilizing Doral's Internet Website

Enrolled Participating Providers may submit claims directly to Doral 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 Beneficiary's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.doralusa.com. Once you have entered the website, click on "Doral Dental USA", 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 Doral 6 digit Location ID prior to logging in. Once logged in, select "enter a claim now" and enter the Beneficiary's applicable information in the field provided. It is NOT necessary to enter the Beneficiary's last name and/or first initial; only the identification number, date of birth, and date of service are required. Next you will click on the word "before" that appears below the Beneficiary's DOB field to verify eligibility and populate the name fields automatically. Once this information is generated you may now begin to 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 Department at 888.560.8135 or via e-mail at:

operations@doralusa.com

5.02 Electronic Claim Submission via Clearinghouse

Dentists may submit their claims to Doral via Affiliated Network Services (ANS), EMDEON or Lindsay Consulting. Doral's current relationship with ANS offers **FREE** transmission for ALL Doral Dental claims. Additional clearinghouses may be added in the future.

You can contact your software vendor and to ensure Doral is listed as a payer. Your software vendor will provide you with the information you need to ensure that submitted claims are forwarded to Doral.

5.03 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, Doral 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@doralusa.com to inquire about this option for electronic claim submission**.**

5.04 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, Doral has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry

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required standards and increase the accuracy and efficiency of claims administered by Doral Dental:

- 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 Doral Dental 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 Doral Dental 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 Doral Dental 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.

5.05 Paper Claim Submission

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

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

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

The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. To ensure proper claim processing, the claim form must include the following:

- The treating Provider's name;
- The treatment location;
- The billing (business office) location;
- The treating Provider's Doral Provider ID or Illinois License Number; and
- All pertinent National Provider Identification (NPI) numbers.

Doral required NPI numbers on all incoming claims beginning May 23, 2008. Doral encourages providers to use the 2006 ADA claim form. On the 2006 ADA claim form, fields 49 and 54 have been allocated for NPI. Field 54 is to be populated with the individual or Type I NPI number and field 49 should be populated with the group or Type II NPI number.

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

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

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

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

Mail paper claims to the following address:

Doral Dental Services of IL, LLC
Claims
12121 N. Corporate Parkway
Mequon, WI 53092

5.06 Claims Adjudication and Payment

Doral adjudicates claims on a weekly basis.

The average turn around time between receipt of a clean claim and adjudication is 14 days. During this 14-day period, Doral imports the data, edits the data for completeness and correctness, analyzes the data for clinical and coding correctness/appropriateness, and audits against product and benefit limits. Once these edits are complete, a remittance summary and check is printed. This occurs weekly.

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

5.07 Electronic Funds Transfer Program

As a benefit to participating Providers, Doral 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 (**Attachment E**)
- 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 Doral.
  - Via Fax – 262.241.4077 or
  - Via Mail – Doral Dental Services of Illinois, 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 Doral 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 **(Attachment E)**. Changes to bank accounts or banking information typically take 2 -3 weeks. Doral is not responsible for delays in funding if Providers do not properly notify Doral 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

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remittance statements are located on Doral's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.doralusa.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.

5.08 Coordination of Benefits (COB)

When Doral 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, Doral considers the claim as paid in full and no further payment is made on the claim.

5.09 Filing Limits

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

5.10 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, Doral performs an edit of all claims upon receipt. This edit validates Beneficiary eligibility, procedure codes and provider identifying information. A Doral 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 feel free to contact Doral's Provider Relations Department at 888.875.7482 with any questions you may have regarding claim submission of your remittance.

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

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

Doral Dental Services of Illinois, LLC
APPEALS
12121 North Corporate Parkway
Mequon, WI 53092

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

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

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6.00 Inquiries, Complaints and Appeals

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

Inquiry

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

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

Complaints

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

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

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

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

1.888.875.7482

The address to file a complaint is:

Doral Dental Services of Illinois, LLC
Complaint Representative
12121 North Corporate Parkway
Mequon, WI 53092

Appeals

A. Beneficiary Appeals

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

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

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

Beneficiaries request a hearing by calling the Fair Hearings Section at 1.800.435.0774 (TTY: 312.793.2697 or 800.526.0857) or by writing to HFS, Bureau of Administrative Hearings, 401 South Clinton Street, 6th floor, Chicago, IL 60607.

Appeals are reviewed by HFS under its existing administrative appeal procedure, and matters are heard before an Administrative Hearing Officer. Doral approves and allows

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payment for any services ordered rendered by HFS or any Court of jurisdiction, provided the Beneficiary is eligible.

B. Dentist Appeal Procedures

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

Doral Dental Services of Illinois, LLC
12121 North Corporate Parkway
Mequon, WI 53092
888.281.2076
Fax 262.241.7401

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

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

C. Quality Control/Peer Review

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

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

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

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

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7.00 Health Insurance Portability and Accountability Act (HIPAA)

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

Doral has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA.

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

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

Note: Copies of Doral's HIPAA policies are available upon request by contacting Doral's Customer Service Department at 888.281.2076 or via e-mail at denelig.benefits@doralusa.com.

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

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8.00 Utilization Management Program

8.01 Introduction

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

8.02 Community Practice Patterns

To ensure fair and appropriate reimbursement, Doral 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, Doral'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. Doral's Utilization Management Programs recognize that there is 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.

8.03 Evaluation

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

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

8.04 Results

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

8.05 Fraud and Abuse

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

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

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

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

Deficit Reduction Act of 2005: The False Claims Act

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. The DRA is a bill designed to reduce federal spending on entitlement programs over five years. The DRA requires that any entity that receives or makes annual Medicaid payments of a least $5 million establish written policies for its employees, management, contractors and agents regarding the False Claims Act (the "FCA").

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

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

For more information about the False Claims Act go to: www.TAF.org

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

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

The Illinois Office of the Inspector General at
1.888.814.4646

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9.00 Illinois Dental Provider Enrollment Process

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

Provider enrollment application forms are available on Doral's website at www.doralusa.com

To assist Providers in the enrollment process, Doral employs two Provider Relations Representatives in Illinois:

Provider Relations Representative – Northern Illinois
Nick Barnette
Phone: 1.800.710.2629
E-Mail: ndbarnette@doralusa.com

Provider Relations Representative – Central and Southern Illinois
Kelly Pulliam
Phone: 866.585.2920
E-Mail: klpulliam@doralusa.com

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

9.01 Existing Providers

Location Change or Addition – Payee (Billing Address) Unchanged

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

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

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

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

9.02 Provider Referral Profile

Doral does not publish a list of participating Providers. Beneficiaries receive provider referrals by calling Doral's Customer Service toll-free at 888.286.2447.

Once enrolled, a Provider is added to Doral's GeoAccess Referral Program, which assists a Beneficiary in locating a participating Provider close to his or her home address. Unless notification is received instructing otherwise, a newly enrolled Provider's status is entered as "Active, Accepting New Patients."

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A provider may change his or her referral status with a simple call to Doral's Provider Relations Department at 888.875.7482. There is no limit to how often a provider may change his or her referral status. In fact, many participating dentists cite this flexibility in Doral's GeoAccess Referral Program as the primary reason they choose to participate in the Illinois HFS Dental Program.

Providers can limit their practices to specified age groups, to certain disabilities, and/or to beneficiaries requiring identified procedures. In addition, Providers can limit their practices to referrals from a certain provider or from a specified geographic area.

To make referral status changes call:

Doral's Provider Relations Department at 888.875.7482.

9.03 Provider Re-enrollment Process

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

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

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

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

HFS' Provider Participation Unit (PPU) initiates a re-enrollment effort on an annual basis. The goal is to refresh each participating provider's enrollment forms every 5 years. A letter is sent from HFS' Provider Participation Unit in February explaining the process and requesting that all forms enclosed with the letter are returned to the HFS Provider Participation Unit within a specified time frame. If the Provider fails to do so, his/her participation is terminated on July 1st of the given year. As part of the process two follow-up letters are mailed by PPU to assure that any Provider who wishes to continue his or her participation in the HFS Dental Program (All Kids) has an opportunity to submit the required documentation.

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

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

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

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

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10.00 The Patient Record

A. Organization

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

   a. Registration data including a complete health history
   b. Medical alert predominantly displayed
   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, or identification number on each page).

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

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

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

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

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

3. An adequate health history that documents:

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

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

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

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

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

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

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

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

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

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

8. Radiographs, which are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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C. Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

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11.00 Quality Improvement Program

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

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

A copy of Doral's Quality Improvement Program is available upon request by contacting Doral's Customer Service Department at 888.281.2076 or via e-mail at:

denclaims@doralusa.com.

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

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

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

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

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

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

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

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12.00 All Kids School-Based Dental Program

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

Recognizing the challenges presented to providers participating in the All Kids School-Based Dental Program, unique protocols have been developed for this aspect of the HFS Dental Program.

12.01 Participation Guidelines and Forms

Providers who wish to participate as an All Kids School-Based Dental Program Provider must meet the following requirements:

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

The process for provider enrollment is outlined in Section 9.00.

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

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

3. **All Kids School-Based Dental Program Providers must complete an Illinois All Kids School-Based Dental Program Provider Registration application. (Attachment Q)**

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

Each entity must submit its annual (based upon school year) schedule of school-based events, no later than 30 days prior to the start of the current school year.

This event schedule must include the date(s) and the location(s) of the event, as well as a list of Providers who will render all follow-up care required by Beneficiaries.

Any additions/changes/deletions to the schedule must be submitted to Doral as soon as possible, but no later than 30 days after a previously unscheduled event occurred. Any additions to the schedule must also include the list of Providers who will render all follow-up care required by Beneficiaries.

An easy means to meet this requirement is to submit an updated schedule to Doral at least once every 30 days – the schedule should show any previously unscheduled events that occurred during the previous 30 days as well as an updated schedule of future events.

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

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A copy of this form can be found on the IDPH Website at:
http://www.idph.state.il.us//HealthWellness/oralhlth/DentalExamProof.pdf

The completed IDPH Proof of School Exam Forms should be forwarded to the school staff member (secretary, principal, school nurse, counselor, etc) coordinating the All Kids School-Based Dental Program services. The completed forms remain at the school. If a Proof of School Exam Form is completed in an office setting, the form is given to the Beneficiary (or parent/guardian) for him/her to provide to the school.

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

5. All Kids School-Based Dental Program Providers must complete a School Exam Follow-up Form (to be sent home with student) for every child seen. (Attachment S)

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

The form must provide the Beneficiary's "Oral Health Score" and contact information for Provider(s) willing to provide restorative follow-up care to the Beneficiary (if follow-up care is required).

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

To obtain the required Microsoft Excel form electronically, as well as the password required for this password-protected document, please contact the HFS Dental Program Coordinator at 217-557-5438. HFS Dental will email the required form.

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

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

Attachment U provides an example of the required Microsoft Excel form.

7. All Kids School-Based Dental Program Providers must complete and maintain a dental record for each Beneficiary receiving school-based services. This record must include relevant components of "The Patient Record", as outlined in Section 10.00.

An example of a Dental Record Form is included in **Attachment W**.

8. All Kids School-Based Dental Program Providers must obtain a permission slip for each Beneficiary prior to providing services.

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

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

An example of a Permission Slip Form is included in **Attachment V**.

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Providers who do not adhere to any portion of the above requirements for participation in the All Kids School-Based Dental Program may not be eligible for reimbursement.

*****Beginning with the 2007-2008 school year, as a component of participation in the HFS Dental Program, every school provider is required to submit all information contained in *Attachment Q* to Doral Dental Services of Illinois, LLC.**

12.02 Place of Service (POS) Definition

Services designated as "school-based" are those that are limited to the five preventive codes. In this situation the treating provider does not provide the full scope of dental services (restorative, diagnostic. etc.).

12.03 Designating a POS on a Claim

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

- For paper claims, mark the "other" box in the place of service field, #38 and, if applicable, put the name of the school where services were performed in the remarks field, #35.
- For electronic claims, in the place of service field, type 03 for "school", or 15 for "other".

If claims for services, other than the five preventive services, are submitted with POS "school," all services on the claim are denied.

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13.00 Clinical Criteria – Children Under age 21

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

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

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

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

13.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

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

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

Narrative demonstrating medical necessity may be needed.

Criteria

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

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13.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

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

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

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.
- Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for crowns will not meet criteria if:

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

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13.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

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

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

Criteria

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

Root canal therapy must meet the following criteria:

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

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

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

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

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

- Tooth does not demonstrate 50% bone support.

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

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

Other Considerations

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

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

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

Criteria

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

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

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

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

- A lesser means of restoration is possible.

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

13.05 Criteria for Operating Room (OR) Cases

Criteria

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

13.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

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

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Criteria

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

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

Authorizations for Removable prosthesis will <u>not</u> 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.

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- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

13.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

- The tooth has less than 50% bone support.

- The tooth has subosseous and/or furcation caries.

- The tooth is a primary tooth with exfoliation imminent.

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

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

13.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).

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

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

Criteria

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

- Documented local anesthesia toxicity.

- Severe cognitive impairment or developmental disability.

- Several physical disability.

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

13.09 Criteria for Periodontal Treatment

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

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- A narrative of medical necessity may be required if the submitted documentation does not support the need for the requested treatment.

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

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

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

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

Criteria

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

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

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

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13.10 Criteria for Medical Immobilization Including Papoose Boards

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

The patient's record must include:

- Informed consent;
- Type of immobilization used;
- Indication for immobilization;
- Duration of application.

Indications

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

Contraindications

Use of this method must not be used:

- With cooperative patients;
- On patients who, due to their medical or systemic condition cannot be immobilized safely;
- As punishment; or
- For the convenience of the dentist and/or dental staff.

Goals of Behavior Management

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

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

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

3. **General dentists should consider referring to dental specialties those patients who they consider to be candidates for immobilization.**

4. **Dental auxiliaries must not use restraining devices to immobilize children.**

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14.00 Clinical Criteria – Age 21 and Over

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

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

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

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

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14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

- Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity may be needed.

Criteria

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

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14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

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

Criteria

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

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

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.
- Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

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

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14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

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

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

Criteria

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

Root canal therapy must meet the following criteria:

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

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

Payment for Root Canal therapy will not be made if any of the following criteria are met:

- Gross periapical or periodontal pathosis is demonstrated radiographically (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.

- 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 Doral's treatment standards, Doral can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after Doral reviews the circumstances.

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

Criteria

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

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

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

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- 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 Operating Room (OR) Cases

Criteria

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

14.06 Criteria for Removable Prosthodontics (Full Dentures)

Documentation needed for authorization of procedure:

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

Criteria

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

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- 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.

- 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 (full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

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 a favorable prognosis is not present.

- 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 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 before a claim is submitted for payment.

- When billing 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.

14.07 Criteria for the Determination of a Non-Restorable Tooth

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

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

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

- The tooth has less than 50% bone support.

- The tooth has subosseous and/or furcation caries.

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- 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.

14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation are reviewed on a case by case basis. Acceptable conditions include but are not limited to:

Extensive or complex oral surgical procedures such as:

- Documented local anesthesia toxicity.
- Severe cognitive impairment or developmental disability.
- Several physical disability.
- Uncontrolled management problem.
- Extensive or complicated surgical procedures.
- Failure of local anesthesia.
- Documented medical complications.
- Acute infections.

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ATTACHMENT A

General Definitions

The following definitions apply to this Dental Office Reference Manual:

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

- provided by an Enrolled Participating Provider to a Beneficiary;
- authorized by Doral in accordance with the Provider's Certificate of Coverage; and
- submitted to Doral according to Doral's filing requirements.

B. **"Doral"** shall refer to Doral Dental Services of Illinois, LLC.

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

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

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

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

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

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

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

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

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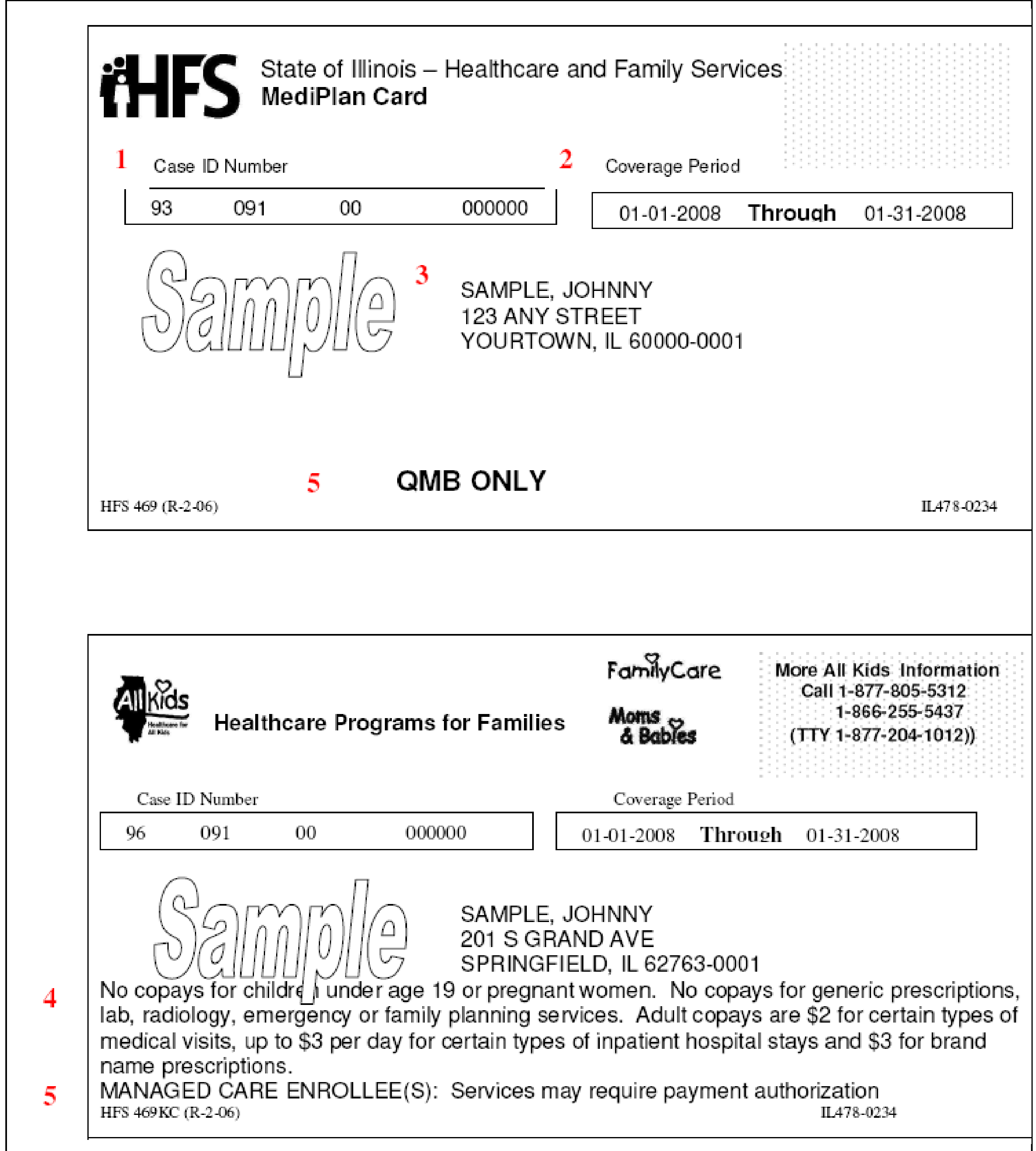
ATTACHMENT B

Healthcare and Family Services Medical Card (Front)



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1 Case ID Number

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

2 Eligibility/Coverage Period

The dates listed in this section are the inclusive beginning and end dates of the coverage period documented by the card. Coverage for periods before or after the dates on the card can be verified by contacting Doral's Provider Relations Department at 1.888.875.7482.

3 Case Name and Address

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

4 Messages

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

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

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

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

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

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

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

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

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

"All Kids Premium Level <#>
Copays apply for most medical services. There are no copays for immunizations for children and well-child visits. To obtain copay status, providers may use the MEDI Website at www.myhfs.illinois.gov, a REV vendor, or call 1-800-842-1461, the Automated Voice Response System."

This message means that a copayment commensurate with the All Kids Premium Level may be collected for dental services. The copayment amounts assigned to each All Kids Premium Level are listed in Attachment Y (page Y-1). For example, for "All Kids Premium Level 4", a $20 copayment may be collected for dental services. However, no copayments may be charged for routine preventive and diagnostic dental services rendered to children, including oral examinations, oral prophylaxis, fluoride treatments, sealants and x-rays.

5 Special Limitations

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

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Healthcare and Family Services Mediplan Card (Back)

1 Items Repeated from the Front of the Card

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

2 Name of Covered Beneficiaries

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

3 Recipient Identification Number (RIN)

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

4 Date of Birth

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

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5 Medicare Coverage

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

CODE	TYPE OF COVERAGE
PART A	HOSPITAL INSURANCE
PART B	MEDICAL INSURANCE
PART AB	BOTH OF THE ABOVE

6 Third Party Liability (TPL)

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

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

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

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

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

8 Total Persons

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

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ATTACHMENT C

THE "DENTAL HOME" CONCEPT

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

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

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

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

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

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

For additional information regarding the All Kids Program, visit the following Web site:
http://www.allkidsdiscovered.com/about.html

For additional information regarding the Dental Home Concept, visit the following Web site:
http://www.aapd.org/search/default.asp

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ATTACHMENT D

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

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

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

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

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

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

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

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

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

MISSING TEETH INFORMATION

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

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

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

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

X

Patient/Guardian signature Date

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

X

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

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

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

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

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

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X

Signed (Treating Dentist) Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56A. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

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

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

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American Dental Association
www.ada.org

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

General Instructions

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

Coordination of Benefits (COB)

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

National Provider Identifier (NPI)

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

Additional Provider Identifier

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

Provider Specialty Codes

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

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

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

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

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ATTACHMENT E

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DORAL DENTAL SERVICES OF ILLINOIS, LLC

INSTRUCTIONS

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

MAINTENANCE TYPE:

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

ACCOUNT HOLDER INFORMATION:

Account Number: ____

Account Type: __________ Checking

__________ Personal __________ Business (choose one)

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

Bank Name: ____

Account Holder Name: ____

Effective Start Date: ____

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

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

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

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

____
Date

____
Phone Number

____
Print Name

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

____
Legal Business/Entity Name (As appears on W-9 submitted to Doral)

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

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Attachment F
Doral Dental Provider Appeal Form

Mail completed forms to:
Doral Dental
Attn: Liz Walsh
12121 N. Corporate Pkwy.
Mequon, WI 53092
Fax 262.834.3452

Beneficiary Name: ______________________________

Member Identification Number: ______________________________

Date of Service: ______________________________

Date EOB was received: ______________________________

Authorization Number: ______________________________

Date Authorization was received: ______________________________

Provider Name: ______________________________

Location Number: ______________________________

Name of Office Contact: ______________________________

Office Phone Number: ______________________________

Reason for Appeal:

____

____

____

____

____

____

Requested Outcome:

____

____

____

____

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First Review____
Second Review____

Models ____
Orthocad ____
Ceph Film ____
X-Rays ____
Photos ____
Narrative ____

ATTACHMENT G

Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

Beneficiary Name: ______________________ Date of Birth: ______________________

Case Name: ______________________ Dentist's Name: ______________________

Examiner: ______________________ Date: ______________________

Records Received:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

Quality:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

A. INTRA-ARCH DEVIATION

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	Point Value	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post			0				X1	

Total Score ___________

Ant = anterior teeth (4 incisors)
Post. = posterior teeth (Include canine, premolars and first molar).
No. = number of teeth affected
P.V. = point value

B. Inter-Arch Deviation
1. Anterior Segment

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	P.V.	Score
						X2	

Total Score ___________

*Score maxillary or mandibular incisors.

2. Posterior Segment

Score Teeth Affected Only	Related Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
	Distal		Mesial		Crossbite		Openbite				
	Right	Left	Right	Left	Right	Left	Right	Left			
Canine											
1st Premolar											
2nd Premolar											
1st Molar											

Total Score ___________

Add 8 points when intra-and intra-arch maxillary incisors score if 6 or more to denote esthetic handicap..___________

Grand Total ___________

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with malocclusion: **Score 8 points for each deviation.**

Deviation	
1. Facial and oral clefts	
2. Lower lip palatal to maxillary incisor teeth	
3. Occlusal interference	
4. Functional jaw limitations	
5. Facial asymmetry	
6. Speech impairment	
7. Total Score	

Possible Surgical Indication
Yes No

TOTAL SALZMANN INDEX:	

Kathie Arena, DDS. David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS Paul Schulze, DDS Richard Nellen, DDS B.N. Marchese, DDS Scott Charmoli, DDS

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Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

Summary of instructions

Score: 2 points for each maxillary anterior tooth affected.
1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
    a. Open spacing. One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth.
    b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially eruption.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the "Handicapping Malocclusion Assessment Record"

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

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A. Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: **A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.**

a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.

d. Spacing

(1) Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).

(2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: **A value of 1 point is scored of each tooth affected.**

a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.

b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.

d. Spacing

(1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).

(2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

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B. Interarch Deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: **A value of 2 points is scored for each affected maxillary tooth only.**

  a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.

  b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.

  c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.

  d. Open-bite refers to vertical interach dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: **A value of 1 point is scored for each affected tooth.**

  a. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.

  b. Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.

  c. Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with a malocclusion: **Score eight (8) points for each deviation.**

1. Facial and oral clefts.
2. Lower lip positioned completely palatal to the maxillary incisor teeth.
3. Occlusal interference that cannot be corrected by a less intrusive therapy.
4. Functional jaw limitations.
5. Facial asymmetry to the extent that surgical intervention is indicated.
6. Speech impairment documented by a licensed or certified therapist whose cause is related to the improper placement of the dental units.

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ATTACHMENT H

Doral Dental USA
837 Dental Companion Guide

For X12N 837 (version 4010A1) 092007
Health Care Claim Submission Implementation Guide

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1.0 Introduction

Section 1.1 What Is HIPAA?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic healthcare transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting standards will eventually improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in healthcare. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards. The standards were not imposed by the law, but instead were developed by a process that included significant public and private sector input. Covered entities are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically.

Additional HIPAA Requirements

- Privacy: Standards must be adopted by all health plans, clearinghouses, and providers to ensure the protection and appropriate disclosure of individually identifiable health information.
- Security: Standards must be adopted by all health plans, clearinghouses, and providers to ensure the integrity and confidentiality of healthcare information. The security rule addresses healthcare information in all types of media, including hard copy and electronic.
- National Identifier Codes: Standards must be adopted by all health plans, clearinghouses, and providers regarding unique identifiers for providers, plans, employers, and individuals (beneficiaries).
- Enforcement: The Office of Civil Rights has been appointed to enforce the privacy rule and has been given the authority to levy penalties for compliance failures. CMS has been designated to monitor the transaction and code sets compliance.

Although this Companion Guide deals with only one aspect of the entire “Administrative Simplification” provision, it is worth noting that all covered entities (health plans, clearinghouses, and providers) and their business partners are required to adhere to all aspects of the provision.

Section 1.2 Purpose of the Implementation Guide

The Implementation Guide specifies in detail the required formats for the electronically submitted transaction from a provider to an insurance company, healthcare payer or government agency. The Implementation Guide contains requirements for the use of specific segments and specific data elements within the segments, and was written for all healthcare providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files.

Section 1.3 How to Obtain Copies of the Implementation Guides

The implementation guides for X12N 837 Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA

Section 1.4 Purpose of this Companion Guide

This Companion Guide was created for trading partners to supplement the 837D Implementation Guide. It contains specific information for the following:

- data content, codes, business rules, and characteristics of the transaction;
- technical requirements and transmission options; and
- information on test procedures that each Trading Partner must complete prior to submitting production 837D transactions to Doral Dental.

This guide is specific to electronic interfaces with Doral Dental. The information in this guide supersedes all previous communications from Doral Dental about this electronic transaction.

Section 1.5 Intended Audience

The Companion Guide transaction document is intended for the technical staff of the external entities that will be responsible for the electronic transaction/file exchanges with Doral. The Companion Guide is available to external entities (providers, third party processors, clearinghouses, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with Doral.

Section 1.6 Introduction to the 837 Dental Healthcare Claims Transaction

The 837 transactions under HIPAA is the standard for electronic exchange of information between two parties to carry out financial activities related to a health care claim. The health care claim or equivalent encounter information transaction is the transmission of either of the following:

- A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
- If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

The 837 Health Care Claim transaction set can be used to submit health care claim billing information, encounter information, or both. It can be sent from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits are required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists and pharmacies and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance benefit. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

This document consists of situational fields for the following transaction type that are required for processing Doral Dental Services Medicaid Dental claims; however, this document is not the complete EDI transaction format. This companion guide is based on the transaction implementation guide, version:

Dental Transaction ASC X12N 837(004010X097A1)

2.0 Trading Partners

Section 2.1 General Overview

All entities desiring to be a Trading Partner must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile Form for each business entity. To obtain the TPA and Profile Form please contact Customer Service at 1-800-341-8478. Please note that the profile information may be given over the telephone in lieu of completing a paper form. Doral will assign a Trading Partner ID for your use in electronic transaction exchange and login into Doral's Trading Partner Web Portal.

Section 2.2 Establishing Connectivity

Doral will maintain various methods of exchanging EDI information. Doral has created a Trading Partner Web Portal to allow trading partners to exchange Dental Claim transactions and this is the preferred method of facilitating EDI exchange. The portal allows a Trading Partner to submit and receive transactions. Outgoing transmissions, including all response transactions and functional acknowledgments will be available only through the Trading Partner Web Portal. Other Trading Partner submission methods include SSL FTP. Contact Customer Service at 1-800-341-8478 with questions about these options.

Encryption is handled automatically as part of SSL (Secured Socket Layer) for the Web Portal or FTP session upon login. Data that pass through the SSL session are encrypted using a 128-bit algorithm and managed via The Verisign $_{tm}$ Secure Site Program.

Section 2.3 Trading Partner Testing

Prior to submitting production 837D claims, the Trading Partner must complete testing. Testing includes HIPAA compliance as well as validating the use of conditional, optional and mutually defined components of the transaction. Contact Customer Service at 1-800-341-8478 to discuss the transmission method, testing process and criteria.

- Test files should contain as many types of claims as necessary to cover each of your business scenarios (original claims, void claims, replacement claims (see Section 6.0 for specific data requirements).

Doral will process these test claims in a test environment to validate that the file meets HIPAA standards and specific data requirements. Once the testing phase is complete and Doral has given its approval, the Trading Partner may submit production 837D transactions to Doral for adjudication. Test claims will not be adjudicated.

3.0 Technical Requirements

Section 3.1 File Size

For 837D transactions, Doral is imposing a limit of 50,000 claim transactions per submission. If you have any questions or would like to coordinate the processing of larger files, please contact Customer Service at 1-800-207-5019.

Section 3.2 Naming Convention

Trading Partner Web Portal users may use any convenient file naming convention for their 837D files claims transmitted to Doral Dental. Doral's system will rename files upon receipt and issue a confirmation number for reference. FTP submitted files must adhere to the following naming convention:

Naming Convention: **P837D_20001_20061010_001**
P – indicates whether this is a production or test (**T**) file
837D – indicates the transaction type
200001 – indicates the 6 digit trading partner ID
20061023 – indicates the date the file was sent (YYYYMMDD)
001 – indicates the sequence number of the file, incremented for subsequent submissions on the same day

Section 3.3 Multiple Transactions Types In a File

Doral does not allow multiple transaction types to be submitted within a single file submission. While the X12 standards do support the handling of multiple transaction set types to be submitted in a single file (ex. 837D and 276), Doral will not support transaction bundling within a file. Transactions types must be sent separately.

Section 3.4 Balancing Data Elements

Doral will use any balancing requirements that can be derived from the transaction implementation guides. All financial amount fields must be balanced at all levels available within the transaction set. The number of transactions in the header and footer must equal and be the same as the number of transactions in the file.

4.0 Acknowledgments

Section 4.1 Functional Acknowledgment Transaction Set (997)

Doral uses the 997 transaction to acknowledge receipt of 837D files. The 997 acknowledgements will be available for download from the Trading Partner Web Portal.

The 997 Functional Acknowledgment Transaction is designed to check each functional group in an interchange for data and syntax errors and send results back to the sending trading partner. The 997 can accept or reject records at the functional group, transaction set, or data element level. Doral's 997 Functional Acknowledgment Transaction will report acceptance or rejection at the functional group and transaction set levels.

5.0 Support Contact Information

Doral Dental Customer Service phone number: 1-800-341-8478.
Email: eclaims@doralusa.com

6.0 Specific Data Requirements

The following sections outline recommendations, instructions and conditional data requirements for submitting 837D transactions to Doral.

Section 6.1 Claim Attachments

An electronic standard for claim attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, Doral has an alternative method for handling electronic claims that require attachments. If you are enrolled and are using the service offered by National Electronic Attachments (NEA), Doral can accept the assigned NEA control/tracking number when reported in the notes segment (NTE segment). For more information about using NEA to submit electronic attachments contact Customer Service at 1-800-207-5019 or you may contact NEA directly at www.nea-fast.com or 1-800-482-5150.

Section 6.2 Predeterminations

Doral will not accept Predetermination of Benefits Claims.

Section 6.3 Coordination of Benefits (COB) Claims

Submit by paper with primary carrier explanation of benefits attached.

Section 6.4 Void Transactions

Void transactions are used by submitters to correct any of the following situations:

- Duplicate claim erroneously paid
- Payment to the wrong provider
- Payment for the wrong member
- Payment for overstated or understated services
- Payment for services for which payment has been received from third-party payers

Void transactions must be submitted for each service line at a time. For example, if a provider wishes to void a claim that was originally submitted with three service lines, the provider must submit three void transactions. Each transaction is for one of the service lines and must include the original generated Doral Claim Encounter Number (CLP07 from the 835 or Encounter # from paper remittance advice)

Section 6.5 Detail Data

Submitters can view the entire set of required data elements in the 837D Implementation Guide. It is recommended that submitters pay special attention to the following segments:

6.5.01 Control Segments

X12N EDI Control Segments
ISA-Interchange Control Header Segment IEA-Interchange Control Trailer Segment GS-Functional Group Header Segment GE-Functional Group Trailer Segment TA1-Interchange Acknowledgment Segment

6.5.02 ISA – Interchange Control Header segment

Reference	Definition	Values
ISA01	Authorization Information Qualifier	00
ISA02	Authorization Information	[space fill]
ISA03	Security Information Qualifier	00
ISA04	Security Information	[space fill]
ISA05	Interchange ID Qualifier	ZZ
ISA06	Interchange Sender ID	[Doral-assigned 6 digit Trading Partner ID]
ISA07	Interchange ID Qualifier	ZZ
ISA08	Interchange Receiver ID	DDS391933153
ISA09	Interchange Date	The date format is YYMMDD
ISA10	Interchange Time	The time format is HHMM
ISA11	Interchange Control Standards Identifier	U
ISA12	Interchange Control Version Number	00401
ISA13	Interchange Control Number	Must be identical to the interchange trailer IEA02
ISA14	Acknowledgment Request	1
ISA15	Usage Indicator	T=Test P=Production
ISA16	Component Element Separator	: (Colon)

6.5.03 IEA – Interchange Control Trailer

Reference	Definition	Values
IEA01	Number of included Functional Groups	Number of included Functional Groups
IEA02	Interchange Control Number	Must be identical to the value in ISA013

6.5.04 GS-Functional Group Header

Reference	Definition	Values
GS02	Application Sender's Code	Must be identical to the values in ISA06
GS03	Application Receiver's Code	DDS391933153
GS04	Date	The date format is CCYYMMDD
GS05	Time	The time format is HHMM
GS06	Group Control Number	Assigned and maintained by the sender
GS07	Responsible Agency Code	X
GS08	Version/Release/Industry Identifier Code	004010X097A1 (Addenda Versions must be used)

6.5.05 GE-Functional Group Trailer

Reference	Definition	Values
GE01	Number of Transactions Sets Included	Number of Transaction Sets Included
GE02	Group Control Number	Must be identical to the value in GS06

6.5.06 Preferred Delimiters

Definition	ASCII	Decimal	Hexadecimal
Segment Separator	~	123	7E
Element Separator	*	42	2A
Compound Element Separator	:	58	3A

6.5.07 Segment Definitions

ISA - Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

IEA - Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange -related control segments. This segment may be thought of traditionally as the file trailer record.

GS - Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

GE - Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

ST - Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

SE - Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

6.5.08 837 Dental Healthcare Claim Transaction

Special attention should be given to the following required segment detail.

Field Definition
Column
- A The name of the loop as documented in the appropriate 837 Implementation Guide.
- B Loop ID used to identify a group of segments that are collectively repeated in a serial fashion up to a specified maximum number of times as documented in the appropriate 837 Implementation Guide.
- C The field position number and segment number as specified in the appropriate 837 Implementation Guide.
- D The data element name and page number as indicated in the appropriate 837 Implementation Guide.
- E The Values and Comments further describe the appropriate 837 Implementation Guide Field data that Doral will accept for processing a claim.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Beginning of Hierarchical Transaction		010-BHT02	Transaction Set Purpose Code Pg 55	‘00’ Original
Beginning of Hierarchical Transaction		010-BHT-06	Transaction Type Code Pg 56	‘CH’ Chargeable
Submitter Name	1000A	020-NM109	Identification Code Pg 61	[Doral assigned 6 digit Trading Partner ID]
Submitter Contact Information	1000A	020-PER05	Communication Number Pg 65	‘TE’ Telephone
Receiver Name	1000B	020-NM103	Name Last or Organization Pg 67	Doral Dental Services

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Receiver Name	1000B	020-NM109	Identification Code Pg 67	DDS391933153
Billing Provider Name	2010AA	015-NM101	Entity Identifier Code Pg 77	'85' Billing Provider
Billing Provider Name	2010AA	015-NM102	Entity Type Qualifier Pg 77	'1' Person '2' Non-Person Entity
Billing Provider Name	2010AA	015-NM103	Billing Provider Name Pg 77	Last Name or Organizational Name
Billing Provider Name	2010AA	015-NM104	Billing Provider Name Pg 77	If NM102= 1, First Name
Billing Provider Name	2010AA	015-NM108	Identification Code Qualifier Pg 78	'XX' National Provider Identifier
Billing Provider Name	2010AA	015-NM109	Identification Code Pg 78	Billing Provider National Provider Identifier
Billing Provider Address	2010AA	025-N301	Address Information Pg 80	Rendering Location Address Line
Billing Provider City/State/Zip Code	2010AA	030-N401	City Name Pg 81	Rendering Location City Name
Billing Provider City/State/Zip Code	2010AA	030-N402	State or Province Code Pg 82	Rendering Location State
Billing Provider City/State/Zip Code	2010AA	030-N403	Postal Code Pg 82	Rendering Location Zip Code (report Zip plus 4)
Billing Provider Secondary Identification Number	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'TJ' Federal Taxpayer's Identification or 'SY' Social Security Number
Billing Provider Secondary Identification Number	2010AA	035-REF02	Reference Identification Pg 84	Federal Taxpayer's Identification or Social Security Number
Billing Provider Secondary Identification Number	2010AA	035-REF01	Reference Identification Qualifier Pg 84	'1D' - Medicaid Provider Number.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Billing Provider Secondary Identification Number	2010AA	035-REF02	Reference Identification Pg 84	Medicaid Provider Number.
Billing Provider Secondary Identification Number	2010AA	035-REF01	Reference Identification Page 84	'G2' Provider Commercial Number
Billing Provider Secondary Identification Number	2010AA	035-REF02	Reference Identification Page 84	Doral Dental Provider ID Number
Billing Provider Secondary Identification	2010AA	035-REF01	Reference Identification Page 84	'LU' Location Number
Billing Provider Secondary Identification	2010AA	035-REF02	Reference Identification Page 84	Doral Dental Location/Office ID Number
Pay to Provider's Name	2010AB	015-NM101	Entity Identifier Code Pg 88	'87' Pay-to-Provider
Pay to Provider's Name	2010AB	015-NM102	Entity Type Qualifier Pg 88	'1' – Person '2' – Non-Person Entity
Pay to Provider's Name	2010AB	015-NM103	Name Last or Organization Name Pg 88	Pay-to-Provider Last Name or Organization Name
Pay to Provider's Name	2010AB	015-NM104	Name First Pg 88	If NM102=1, Pay-to-Provider First Name
Pay to Provider's Name	2010AB	015-NM108	Identification Code Qualifier Pg 89	'XX' National Provider Identifier
Pay to Provider's Name	2010AB	015-NM109	Identification Code Pg 89	Pay-to-Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI from 2010AA is used as the pay-to-provider
Pay to Provider's Address	2010AB	025-N301	Address Information Pg 91	Pay-to Provider Address Line

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Pay to Provider City/State/Zip	2010AB	030-N401	City Name Pg 92	Pay-to Provider City
Pay to Provider City/State/Zip	2010AB	030-N402	State or Province Code Pg 93	Pay-to-Provider State
Pay to Provider City/State/Zip	2010AB	030-N403	Postal Code Pg 93	Pay-to-Provider Zip Code (report Zip plus 4)
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Qualifier Pg 95	'TJ' Federal Taxpayer's Identification Number of 'SY' Social Security Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Qualifier Pg 95	Federal Taxpayer's Identification Number or Social Security Number
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Qualifier Pg 95	'1D' Medicaid Provider Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Pg 95	Medicaid Provider Number. Required when submitting Medicaid claims.
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Pg 95	'G2' Provider Commercial Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Pg 95	Doral Dental Provider ID Number. If this segment is not submitted, the Doral Dental Provider ID Number from 2010AA is used as the pay-to provider number.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Pay to Provider Secondary Identification	2010AB	035-REF01	Reference Identification Pg 95	'LU' Location Number
Pay to Provider Secondary Identification	2010AB	035-REF02	Reference Identification Page 95	Doral Dental Location/Office ID Number. If this segment is not submitted, the Doral Dental Location ID Number from 2010AA is used as the Doral Dental Location/Office ID.
Subscriber Hierarchical Level	2000B	001-HL04	Hierarchical Level Page 97	0-No Subordinate HL Segment in the Hierarchical Structure
Subscriber Information	2000B	005-SBR01	Payer Responsibility Sequence Number Code Pg 99	T-Tertiary
Subscriber Information	2000B	005-SBR09	Claim Filing Indicator Code Pg 102	'MC' Medicaid
Original Reference Number	2300	180-REF01	Reference Identification Qualifier Pg 180	'F8' Original Reference Number
Original Reference Number	2300	180-REF02	Claim Original Reference Number Pg 180	For Claim Frequency Type Code 7 (Void) or 8 (Replacement claim) report original Doral Encounter Identification Number (CLP07 from the 835 or Encounter # from paper remittance)
Rendering Provider Name	2310B	250-NM101	Entity Identifier Code Pg 196	'82' Rendering Provider
Rendering Provider Name	2310B	250-NM102	Entity Type Qualifier Pg 196	'1' Person
Rendering Provider Name	2310B	250-NM103	Name Last or Organization Name Pg 196	Rendering Provider Last Name
Rendering Provider Name	2310B	250-NM104	Name First Pg 196	Rendering Provider First Name

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	**B**	**C**	**D**	**E**
Rendering Provider Name	2310B	250-NM108	Identification Code Qualifier Pg 197	'XX' National Provider Identifier
Rendering Provider Name	2310B	250-NM109	Identification Code Pg 197	Rendering Provider National Provider Identifier. If this segment is not submitted, the billing provider NPI number from 2010AA is used as the rendering provider.
Rendering Provider Secondary Identification	2310B	271-REF01	Reference Identification Qualifier Pg 202	'1D'-Medicaid Provider Number
Rendering Provider Secondary Identification	2310B	271-REF02	Reference Identification	Medicaid Provider Number. Required when submitting Medicaid claims.
Rendering Provider Secondary Identification	2310B	271-REF01	Reference Identification Pg 202	'G2' Provider Commercial Number
Rendering Provider Secondary Identification	2310B	271-REF02	Reference Identification Pg 202	Doral Dental Provider ID Number. If this segment is not submitted, the Doral Dental Provider Number from 2010AA is used as the rendering provider.
Rendering Provider Secondary Identification	2310B	271-REF01	Reference Identification Pg 202	'LU' Location Number
Rendering Provider Secondary Identification	2310B	271-REF02	Reference Identification Pg 202	Doral Dental Location/Office ID Number. If this segment is not submitted, the Doral Dental Location/Office ID Number from 2010AA is used as the rendering location.

Loop Name	Loop ID	837 Field Position & Segment	837 Data Element Name & Page Number from Imp Guide	Valid Values & Comments
A	B	C	D	E
Service Facility Location	2310C	250-NM108	Identification Code Qualifier Pg 204	XX' Health Care Financing Administration National Provider Identifier
Service Facility Location	2310C	250-NM109	Identification Code	NPI reflecting rendering location if you have enumerated. (Typically the Subpart NPI)

7.0 APPENDIX A: LINKS TO ONLINE HIPAA RESOURCES

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org

Association for Electronic Health Care Transactions (AFEHCT)

- A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/.
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

For X12N 837 (version 4010A1) 092007
Health Care Claim Submission Implementation Guide

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

ATTACHMENT I

Patient Recall System Requirements

Recall System Requirements

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

Office Compliance Verification Procedures

In conjunction with its office claim audits described in section 5, Doral will measure compliance with the requirement to maintain a patient recall system.

Participating dentists are expected to meet minimum standards with regard to appointment availability. Emergent situations (those involving pain, infection, swelling and/or traumatic injury) need to be appointed within 24 hours. Urgent care should be available within 72 hours. Initial and Recall routine treatment should be scheduled within 30 days of initial contact with the dentist's office. Follow-up appointments should be scheduled within 45 days of the present treatment date. Providers should see a Beneficiary within 30 minutes of arriving at the office for a scheduled appointment.

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ATTACHMENT J

Office Claim Audit

A. Purpose

Doral utilizes a proprietary paperless process to collect procedure information and determine the value of services rendered by each participating office. Additionally, Doral has substituted specific dental treatment protocols and related documentation requirements for prior-authorization procedures utilized by many traditional dental PPOs.

The resulting streamlined process greatly reduces the administrative burden of Doral's participating dentists by recognizing the fundamental difference between monitoring necessary and appropriate dental services and traditional medical utilization management.

Despite the obvious benefits of the streamlined process, Doral's paperless system could potentially be abused by fraudulent claim entry. In order to assure its dental panel Beneficiaries that such efforts will be identified and appropriately dealt with, Doral has designed a fraud detection program that provides a 98% probability of detecting fraudulent claim submission.

B. Random Chart Audits

On a periodic basis, Doral takes a sample of claims submitted by selected office locations. Doral provides this listing of Beneficiaries and dates of service to the office location. For each Beneficiary and date of service, the office must supply complete dental records to support the services billed. These records will be reviewed to ensure compliance with the Beneficiary record protocols, as well as to detect possible billing irregularities.

Each office may either make copies of the records requested or arrange for a Doral representative to review the original records at the office location itself.

Doral claim audits will be scheduled on a random basis. Doral shall make every effort to schedule these reviews at times that are convenient for the office and will make every effort to complete the review in as short a duration as is practical.

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ATTACHMENT K

Radiology Guidelines

Note: Please refer to benefit tables for benefit limitations.

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

A. Radiographic Examination of the New Patient

Child – Primary Dentition

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

Child – Transitional Dentition

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

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

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

Adult – Dentulous

The Panel recommends and individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

Adult – Edentulous

The Panel recommends a Full-Mouth Intraoral Radiographic Survey or a Panoramic X-ray for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

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

a. Child – Primary and Transitional Dentition

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

b. Adolescent

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

c. Adult – Dentulous

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

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d. Adult – Edentulous

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

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

a. Child – Primary Dentition

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

b. Adolescent

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

c. Adult – Dentulous

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

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

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

4. Growth and Development Assessment

Child – Primary Dentition

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

Child – Transitional Dentition

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

Adolescent

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

Adult

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

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ATTACHMENT L

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME ______________________
Last First Middle

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B L

A B C D E F G H I J

RIGHT LEFT

T S R Q P O N M L K

L B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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ATTACHMENT M

RECALL EXAMINATION

PATIENT'S NAME ____________________

CHANGES IN HEALTH STATUS/MEDICAL HISTORY ____________________

	OK		OK
LYMPH NODES		TMJ	
PHARYNX		TONGUE	
TONSILS		VESTIBULES	
SOFT PALATE		BUCCAL MUCOSA	
HARD PALATE		GINGIVA	
FLOOR OF MOUTH		PROSTHESIS	
LIPS		PERIO EXAM	
SKIN		ORAL HYGIENE	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

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

COMMENTS: ____________________

RECALL EXAMINATION

PATIENT'S NAME ____________________

CHANGES IN HEALTH STATUS/MEDICAL HISTORY ____________________

	OK		OK
LYMPH NODES		TMJ	
PHARYNX		TONGUE	
TONSILS		VESTIBULES	
SOFT PALATE		BUCCAL MUCOSA	
HARD PALATE		GINGIVA	
FLOOR OF MOUTH		PROSTHESIS	
LIPS		PERIO EXAM	
SKIN		ORAL HYGIENE	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

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

COMMENTS: ____________________

<u>NOTE</u>: The above form is intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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ATTACHMENT N

Authorization for Dental Treatment

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

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): ____

Tooth Number(s): ____

Date: _______________________________________

Dentist: ____________________________________

Patient Name: ______________________________

Legal Guardian/
Patient Signature: ____________________________

Witness: ____________________________________

Note: The above form is intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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ATTACHMENT O

MEDICAL AND DENTAL HISTORY

Patient Name: ______________________ Date of Birth: ______________

Address: ____

Why are you here today? ____________________________________

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _________________________________

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: ______________________________

Address: _______________________________________

Telephone: _____________________________________

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: ___________________________

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: ___________________________________

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

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

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

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

Are you on a special diet? ☐ Yes ☐ No

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

If yes, where? _______________________________________

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

If yes, how often and how much? ____________________________

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

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

If yes, please list: ____

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

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

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? ____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature : ______________________________ Date : __________________________

Dentist's Signature: ______________________________ Date: __________________________

Review Date	Changes in Health Status	Patient's signature	Dentist's signature

<u>Note</u>: The above form is intended to be a sample. Doral is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Attachment P

Agreement to Pay Non-Covered Services

Patient Name: ______________________________

Recipient (Medicaid) ID: ______________________________

Guarantor Name: ______________________________

Relationship to Patient: ______________________________

Not all dental services are covered by the HFS/All Kids Dental Program. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above named patient, but are not covered services:

Non-Covered Services

Code	Description

I understand that the above services are not covered by the HFS/All Kids Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

______________________________ ______________

Guarantor Signature Date

Guarantor Address: *Guarantor Phone*

______________________________ Home: ______________

Street, Apt # Cell: ______________

______________________________ Work ______________

City, State, Zip

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ATTACHMENT Q
All Kids School-Based Dental Program Provider Registration

Doral Dental Services of Illinois, LLC
1100 South Fifth Street, Springfield, IL 62703
ATTN: Illinois Outreach Coordinator
Fax (217) 522-8851

*****INCOMPLETE APPLICATIONS WILL DELAY THE APPROVAL PROCESS*****

Providers must complete and submit the following documents in order to participate in the Illinois ***All Kids School-Based Dental Program:***

___1. A **COMPLETED** All Kids School-Based Dental Program Provider Registration Application that is signed and dated in addition to the Illinois HFS Dental Program Provider Enrollment forms.

___2. A copy of your **SCHEDULE OF SCHOOL EVENTS** planned for the upcoming quarter or year. (This needs to be updated monthly, or as events are scheduled and is audited against claims annually)

___3. A copy of your **CURRENT** referral network resource directory for follow-up care to Beneficiaries and/or proof that all public clinics and at least 5 private dental practices in the local area were contacted in an attempt to arrange follow-up care for Beneficiaries.

The following documents are ***REQUIRED*** *on an on-going basis upon completion of school-based exams.*

___ 1. A **COMPLETED** IDPH 'Proof of School Dental Examination' Form;

___2. A **COMPLETED** School Exam Follow-Up Care Form (including contact information for the Provider(s) willing to complete follow-up care, if necessary) to be sent home with the student; and

___3. A roster of the students, who are Beneficiaries, receiving care, including the students' names, Recipient ID's, Date of Service and their corresponding Oral Health Scores, to be sent password protected via e-mail to HFS.dental@illinois.gov

PLEASE REMEMBER:

- **A SITE REVIEW MAY BE REQUIRED PRIOR TO APPROVAL FOR NEW PROVIDERS;**
- **PROVIDER CANNOT BE PAID FOR SCHOOL-BASED SERVICES RENDERED TO BENEFICIARIES UNTIL FINAL APPROVAL FROM DORAL IS RECEIVED, THIS PROCESS WILL TAKE APPROXIMATELY 2-4 WEEKS; and**
- **ADDITIONAL AUDITS MAY BE CONDUCTED TO PROVE BEST EFFORTS HAVE BEEN MADE BY THE SCHOOL PROVIDER TO ENSURE THAT MEMBERS ARE RECEIVING NECESSARY FOLLOW-UP TREATMENT.**

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ILLINOIS ALL KIDS SCHOOL- BASED DENTAL PROGRAM

PROVIDER REGISTRATION APPLICATION

School Based Provider Entity Name				Phone #: Fax #: E-Mail Address:
Billing Office Contact Name	Billing Office Contact Title			
Billing Office Address	City		State	Zip Code

OFFICE INFORMATION

Participating School Providers	HFS Dental Program ID (RIN)	Dentist Signature

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CERTIFICATION, STATEMENTS, AND SIGNATURE

I hereby acknowledge that the information provided in this application is material to the determination by DORAL whether or not to execute your request. I hereby represent and warrant that all information provided herein is true to the best of my knowledge, and I agree to notify DORAL in the event an error is discovered or when new events occur which alter the validity of any response herein. I also agree to update the annual schedule of events and supply all necessary member information required to Doral on a timely manner upon completion.

I certify that:

* All services are provided by and under the supervision of a licensed dentist; and
* The above information is complete, correct and true to the best of my knowledge.

Signed by: ______________________________ Date: ________________________________

Entity's Owner or Owner's Designee

Please print name: ______________________________________

All applications are subject to review and approval by DORAL.

All information contained will be held in strict confidence, and available for review by only duly authorized employees of Doral Dental Services of IL, LLC or HFS. Any corrections, additions, or clarifications to these files must be submitted in writing to the Doral Dental Services of IL, LLC Outreach and Quality Coordinator. The practitioner has the right, upon request, to be informed of the status of their application via phone, fax, or mail.

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ILLINOIS ALL KIDS SCHOOL-BASED DENTAL PROGRAM

PROVIDER SCHEDULE OF EVENTS

Calendar Year: ___________________________

Date	Event/School Name	Event/School Address	Provider Name	Staff Present	Anticipated Number of Members

Please make copies of this form if additional room is needed

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ILLINOIS ALL KIDS SCHOOL-BASED DENTAL PROGRAM

PROVIDER REFERRAL NETWORK

School-based Providers must demonstrate a good faith effort to develop a referral network for follow-up care in the communities in which school based services are rendered.

Please attach a list of the dental Providers willing to render all follow-up care (diagnostic, restorative, etc.) to the students in the communities in which school-based services are rendered. The listing must include:

- Provider Name
- Provider Address (Street, City, State, ZIP)
- Provider Phone Number
- School Community(ies) Served

In communities where a referral network is not present, the school-based Provider must submit proof that all public clinics and at least five (5) private dental providers were contacted. Proof of contact must include:

- Provider/Clinic Name
- Provider Address (Street, City, State, ZIP)
- Provider Phone Number
- School Community(ies) Served
- Date Contacted
- Contact Name

In instances where a referral network is not available, the school-based Provider should provide Doral's toll-free phone number for Beneficiary Customer Service (1.888.286.2447) on the School Exam Follow-up Form for Provider referral.

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ATTACHMENT R

Sample Letter to Referral Network Providers

DATE

Dear ***(Name of community provider)*:**

(Name of school-based dental provider) is a school- based dental service program providing preventive dental services to children within schools located in your community and the surrounding area. We want to partner with you in providing better dental services to the children in this program.

Our services within the school are directed toward children receiving dental benefits through the Illinois Department of HFS (HFS) All Kids Dental Program. In the school, each child typically receives an examination, fluoride treatment, prophylaxis, and sealants (if not placed previously).

What can you do to help?

All too often our dentists encounter children requiring more extensive dental treatment that cannot be provided in the school setting. Our goal is to find dental homes for these children in their communities where they we they can receive needed restorative, diagnostic and ongoing preventive services. In an effort to improve the oral health status of children in your community, we would like to include your office in our referral network.

Will you get paid?

Yes! The HFS/All Kids Dental Program allows payment for an exam and fluoride twice per year (one time in a school based setting and anther time in an office based setting). Moreover, the program allows prophylaxis four times per year (once every six months in the school setting and once every six months in an office setting).

Will my practice be inundated with All Kids Program Beneficiaries?

No. Doral Dental Services of Illinois, LLC (Doral), HFS' dental benefit administrator, does not publish a list of participating providers. Doral's system allows providers to tailor their referral profiles. For example, providers determine if they only want to see certain types of patients, patients within a specific age range, patients living within a defined geographic area, or existing patients only. A Beneficiary does not receive your information unless he/she meets you referral profile.

If you are not enrolled in the HFS Dental Program (this includes the All Kids Dental Program) we encourage you to contact Doral at 1-888-875-7482 to answer any questions you may have about participation. A Doral Provider Representative is happy to come to your office to assist you in completing the enrollment paperwork and developing your referral profile.

If all local dentists agreed to care for as few as five All Kids Dental Program patients from your community, an important contribution would be made to the dental success and oral health of these children. We hope you seriously consider our request. In an effort to create a profile of the dental community in your area we ask that you please complete the enclosed survey and return it to us in the enclosed self-addressed stamped envelope. If you have any questions regarding our school-based dental services program, you may call _____________ at **(school provider's phone #)**.

In advance, thank you for completing the survey and we hope you choose to partner in this rewarding program dedicated to the dental care of the underserved children in your community.

Sincerely,
(School Provider Name)

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ATTACHMENT S

SCHOOL EXAM FOLLOW-UP CARE FORM

To be given to student for communication to parent/guardian

Student's Name: ____
Last First M.I.

Oral Hygiene Status

_______ Good _______ Fair _______ Poor

Periodontal (Gum) Status

_______ Good _______ Fair _______ Poor

Cavity(ies) Present

_______ Yes _______ No

Problem Teeth Indicated By "X"

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B L B L

A B C D E F G H I J

RIGHT LEFT

T S R Q P O N M L K

L B L B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Treatment Received

_______ Dental Exam/Screening

_______ Prophylaxis (Cleaning)

_______ Fluoride Treatment (gel)

_______ Fluoride Treatment (varnish)

_______ Dental Sealants (List Teeth)

____

____

Notes/Comments:

Oral Health Assessment Rating	
Score	**Description**
3	Urgent Treatment – Advanced dental disease including signs or symptoms of pain, infection, exposed nerve or swollen/bleeding gums.
2	Restorative Care – Decayed teeth that need either fillings or crowns.
1	Preventive Care (services rendered today) – There are no visual signs of problems with the teeth or gums. See your dentist on a routine basis.

Student's Oral Health Assessment Rating:

____
Score

If you do not have a regular dentist or dental home, contact this provider for follow-up care:

Name	Phone Number
Address	

Treatment Date: _______________ Dentist Name: ______________________

Dentist Signature: ______________________

Doral's Customer Service Toll-Free Number: 1-888-286-2447

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ANEXO S

FORMULARIO DE ATENCIÓN DE SEGUIMIENTO DE EXÁMENES ESCOLARES

Entregárselo al alumno para que se lo comunique al padre/tutor

Nombre del alumno: ______________________________

Apellido | Nombre | Inicial del segundo nombre

Estado de higiene oral

_____ Bueno _____ Aceptable _____ Malo

Estado periodontal (encías)

_____ Bueno _____ Aceptable _____ Malo

Caries presentes

_____ Sí _____ No

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

B L

A B C D E F G H I J

Derecha Izquierda

T S R Q P O N M L K

L B

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Tratamiento recibido

_____ Examen/Revisión dental

_____ Profilaxis (limpieza)

_____ Tratamiento de fluoruro(gel)

_____ Tratamiento de fluoruro (esmalte)

_____ Sellado dental (enliste dientes)

____

____

Notas/comentarios:

Calificación de evaluación de salud oral	
Calificación	**Descripción**
3	Tratamiento de urgencia: absceso, exposición del nervio, estado avanzado de enfermedad, síntomas o signos que incluyen dolor, infecciones o hinchazón.
2	Atención reconstituyente: amalgamas, resinas compuestas, coronas, etc.
1	Atención preventiva (servicios prestados en el momento): no existe evidencia visual de caries o patología periodontal. Consulte a su dentista cada 6 meses para un examen dental.

Calificación de evaluación de salud oral del alumno:

_____
Calificación

Si no cuenta con un consultorio odontológico o dentista de cabecera, comuníquese con este proveedor para recibir atención de seguimiento:

Nombre | Número telefónico

Dirección

Fecha de tratamiento: _____________ Nombre del dentista: ______________________

Firma del dentista: ______________________

Número telefónico gratuito del Servicio de Atención al Cliente de Doral: 1-888-286-2447

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ATTACHMENT T

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note ______________________________

Signature of Dentist ______________________ Date ______________

Address ______________________ Telephone ______________
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

Printed by Authority of the State of Illinois
P.O.#346085 5M 10/05

A copy of the IDPH Proof of School Dental Examination Form can be found on line at:
http://www.idph.state.il.us//HealthWellness/oralhlth/DentalExamProof.pdf

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ATTACHMENT U

Make copies of this form, as needed.

School-Based Provider/Entity Name: ________________________________

ILLINOIS ALL KIDS SCHOOL-BASED DENTAL PROGRAM
School Event Student Roster

Student Last Name	Student First Name	Recipient ID	Date of Service	Oral Health Score

Submit completed form within 30 days of completed school event via e-mail to:
hfs.dental@illinois.gov

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ATTACHMENT V

ALL KIDS SCHOOL-BASED DENTAL PROGRAM PERMISSION FORM
(sample)

DENTAL EXAM
MUST BE RETURNED TOMORROW

PLEASE PRINT IN INK

If you are not interested in this program, please print your child's name and put "NO" on this form.

NAME OF SCHOOL:____
TEACHER:____________________________________ GRADE: ____________
COUNTY: ____________________________________

Dear Parent or Guardian,
(name of entity) and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists and assistants will come to your child's school with portable equipment. In order for your child to receive these services **YOU MUST PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.**

YOUR CHILDS NAME:___________________________BIRTH DATE: ___/___/___ GENDER: M F

ADDRESS:_________________________CITY/ZIP:________________HOME PHONE:( )____-_____
DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES NO
OF FAMILY MEMBERS: ____ INCOME PER YEAR (optional): _________

IS YOUR CHILD ENROLLED IN THE 'ALL KIDS' PROGRAM: YES NO
IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___
9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES NO
Name of Insurance Company____
Insurance Telephone Number _______- _________________ Group Number ______________
Employer Name ____
Name of Insured ___________________________________ Date of Birth__________________
Social Security Number of Insured Person _______________________

Has your child had any history of, or conditions related to, any of the following:

____ Anemia	____ Chronic Sinusitis	____Growth problems	____ Seizures
____Asthma	____ Diabetes	____ Hearing	____Thyroid
____Bleeding disorders	____ Ear aches	____ Heart	____Tobacco/ drug use
____ Cancer	____ Epilepsy	**____ Latex allergy	
____ Cerebral Palsy	____ Fainting	____Pregnancy (teens)	Other_____________

Is your child taking any over the prescription and/or over the counter medications at this time? YES NO
If yes, please list: ____
Does your child have any speech difficulties? YES NO
Has your child ever suffered injuries to the mouth, head or teeth? YES NO
What type of water does your child drink? __City water __ Well water __Bottled water __ Filtered water

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED
I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/ school representative and dental provider access to child's dental record.

SIGNATURE:____________________________________ **DATE:**____________________
**** In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA.**
**** This will also give permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.**

Dentist's Initials ___________

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ATTACHMENT W

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD
(sample)

TO BE COMPLETED BY DENTIST

TREATMENT RECEIVED:
___ EXAM
___ PROPHYLAXIS
___ DENTAL SEALANTS
___ FLUOIRDE TREATMENT (gel)
___ FLUORIDE TREATMENT (varnish)

CURRENT DENTAL STATUS OF PATIENT

PRIOR TREATMENT:

RESTORATIONS	SEALANTS
____________________	____________________
____________________	____________________
____________________	____________________

TREATMENT NEEDED:

RESTORATIVE	SEALANTS (placed today)
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

ORAL HYGIENE STATUS: ___ Good ___ Fair ___ Poor

PERIODONTAL STATUS: ___ Good ___ Fair ___ Poor

ORAL HEALTH ASSESSMENT RATING:

1. Preventive Care (services rendered today)- There is no visual evidence of caries activity or periodontal pathology.
2. Restorative Care- Amalgams, composites, crowns, etc.
3. Urgent Treatment- Abscess, nerve exposure advanced disease state, signs or symptoms that include pain, infection or swelling.

ORAL HEALTH ASSESSMENT SCORE: _____

NOTES: ____
____
____

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

Dentist's Signature: ________________________________ Treatment Date: ______________

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ATTACHMENT X

Covered Services Comparison for Children and Adults

	Children (< age 21)	**Adults** (> age 20)	**Requires Prior Approval**
DIAGNOSTIC SERVICES			
Oral Exams (For children, limited to one every 6 months per dentist in an office setting, and one every 12 months in a school setting. For adults, limited to 1st visit per dentist.)	X	X	
X-rays	X	X	
PREVENTIVE SERVICES			
Prophylaxis – Cleanings (Once every 6 months)	X		
Topical Fluoride (Annual)	X		
Sealants	X		
Space Maintenance	X		
RESTORATIVE SERVICES			
Amalgams	X	X	
Resins	X	X	
Crowns (For adults, limited to facial front teeth only.)	X	X	Y
Sedative Fillings	X	X	
ENDODONTIC SERVICES			
Pulpotomy	X		
Root Canals (For adults, limited to facial front teeth only.)	X	X	
PERIODONTAL SERVICES			
Gingivectomy	X		Y
Scaling and Root planning	X		Y
REMOVABLE PROSTHODONTIC SERVICES			
Complete Denture (upper and lower)	X	X	Y
Partial Denture (upper and lower)	X		Y
Denture Relines	X	X	Y
Maxillofacial Prosthetics	X	X	Y
FIXED PROSTHETIC SERVICES			
Bridge	X		Y
ORAL AND MAXILLOFACIAL SERVICES			
Extractions	X	X	
Surgical Extractions	X	X	Y
Alveoloplasty	X		Y
ORTHODONTIC SERVICES			
Orthodontia (Coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index)	X		Y
ADJUNCTIVE GENERAL SERVICES			
General Anesthesia	X	X	Y
IV Sedation	X	X	Y
Nitrous Oxide	X	X	
Conscious Sedation	X	X	Y
Therapeutic Drug Injection	X	X	Y

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ATTACHMENT Y

Doral Dental Services of Illinois, LLC

HFS Dental Program Fee Schedule for Children and Adult Beneficiaries
Rates Effective July 1, 2009
Please note: Adults have limited dental coverage. All services not covered are noted as N/A.

Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D0120	Periodic Oral Exam – Ages 0 thru 18	28.00	N/A
D0120	Periodic Oral Exam –Ages 19 thru 20	16.20	N/A
D0140	Limited Oral Examination – Problem Focused	16.20	16.20
D0150	Comprehensive Oral Examination	21.05	21.05
D0210	Intraoral-Complete Series (including bitewings)	30.10	30.10
D0220	Intraoral – periapical – first film	5.60	5.60
D0230	Intraoral periapical – 1 additional film	3.80	3.80
D0270	Bitewings Single Film	5.60	5.60
D0272	Bitewings-Two Films	9.40	9.40
D0274	Bitewings-Four Films	16.90	16.90
D0277	Vertical Bitewings – 7-8 Films	16.90	16.90
D0330	Panoramic Film	22.60	22.60
D1120	Prophylaxis - Child – Ages 0 thru 18	41.00	N/A
D1120	Prophylaxis - Child – Ages 19 thru 20	25.40	N/A
D1203	Topical Application of Fluoride (excluding prophy) – Ages 0 thru 18	26.00	N/A
D1203	Topical Application of Fluoride (excluding prophy) – Ages 19 thru 20	14.85	N/A
D1206	Topical Fluoride Varnish -Ages 0 thru 18	26.00	N/A
D1206	Topical Fluoride Varnish -Ages 19 thru 20	14.85	N/A
D1351	Sealant – Per Tooth	36.00	N/A
D1510	Space Maintainer - Fixed Unilateral	70.60	N/A
D1515	Space Maintainer - Fixed Bilateral	103.50	N/A
D1520	Space Maintainer – Removable Unilateral	70.60	N/A
D1525	Space Maintainer - Removable Bilateral	74.70	N/A
D1550	Space Maintainer – Recement	10.70	N/A
D2140	Amalgam-1-Surface, Primary or Permanent	30.85	30.85
D2150	Amalgam-2-Surfaces, Primary or Permanent	48.15	48.15
D2160	Amalgam-3-Surfaces, Primary or Permanent	58.05	58.05
D2161	Amalgam-4+-Surface, Primary or Permanent	58.05	58.05
D2330	Resin-Based Composite - 1-Surface, Anterior	34.60	34.60
D2331	Resin-Based Composite - 2-Surfaces, Anterior	51.90	51.90
D2332	Resin-Based Composite - 3-Surfaces, Anterior	61.80	61.80
D2335	Resin-Based Composite – 4+ surfaces, or involving Incisal Edge, Anterior	61.80	61.80
D2391	Resin-Based Composite – 1-surface, Primary or Permanent	30.85	30.85
D2392	Resin-Based Composite – 2-surfaces, Primary or Permanent	48.15	48.15
D2393	Resin-Based Composite – 3-surfaces, Primary or Permanent	58.05	58.05
D2394	Resin-Based Composite – 4+surfaces, Primary or Permanent	58.05	58.05
D2740	Crown – porc/ceramic	235.20	235.20
D2750	Crown – porc/metal high noble	235.20	235.20
D2751	Crown - Porcelain/Base Metal	235.20	235.20
D2752	Crown – porcelain/metal noble	235.20	235.20
D2790	Crown – full metal high noble	145.85	145.85
D2791	Crown - Full Cast Base Metal	145.85	145.85
D2792	Crown – full metal noble	145.85	145.85
D2910	Recement Inlays	11.30	11.30
D2915	Recement cast or prefabricated post and core	23.50	23.50

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D2920	Recement Crown	23.50	23.50
D2930	Prefabricated Stainless Steel Crown (SSC) Primary Tooth	73.40	N/A
D2931	Prefabricated Stainless Steel Crown (SSC) Permanent Tooth	73.40	N/A
D2932	Prefabricated Resin Crown	56.45	56.45
D2933	Prefabricated Stainless Steel crown with resin window	56.45	N/A
D2940	Sedative fillings	11.30	11.30
D2950	Core buildup, including any pins	58.05	58.05
D2951	Pin Retention-Per Tooth	9.40	9.40
D2954	Prefabricated Post and Core	32.90	32.90
D3220	Therapeutic Pulpotomy	52.70	N/A
D3230	Pulpal Therapy – (restorbable filing) – anterior, primary tooth (excl. final restoration)	52.70	N/A
D3310	Anterior Root Canal (Excluding Final Restoration)	136.40	136.40
D3320	Bicuspid Root Canal (Excluding Final Restoration)	155.25	N/A
D3330	Molar Root Canal (Excluding Final Restoration)	202.30	N/A
D3351	Apexification/Recalcification Initial Visit	28.20	N/A
D3352	Apexification/Recalcification Interim Visit	14.10	N/A
D3353	Apexification/Recalcification Final Visit	14.10	N/A
D3410	Apicoectomy/Periadicular Surgery — Per Tooth, First Root	112.90	N/A
D4210	Gingivectomy or Gingivoplasty — 4+ Teeth, Per Quadrant	131.70	N/A
D4211	Gingivectomy or Gingivoplasty — 1 to 3 Teeth, Per Quadrant	65.85	N/A
D4240	Gingival Flap Procedure, w/ Root Planing – 4+ Teeth, Per Quadrant	229.60	N/A
D4241	Gingival Flap Procedure, w/ Root Planing – 1 to 3 Teeth, Per Quadrant	114.80	N/A
D4260	Osseous Surgery – 4+ Teeth, Per Quadrant	277.60	N/A
D4261	Osseous Surgery – 1 to 3 Teeth, Per Quadrant	138.80	N/A
D4263	Bone Replacement Graft — First Site in Quadrant	141.15	N/A
D4264	Bone Replacement Graft, Each Additional Site in Quadrant	70.60	N/A
D4270	Pedicle Soft Tissue Graft	141.15	N/A
D4271	Free Soft Tissue Graft	141.15	N/A
D4273	Subepithelial Connective Tissue Graft Procedure	141.15	N/A
D4274	Distal or Proximal Wedge	70.60	N/A
D4320	Provisional Splinting, Intracoronal	188.20	N/A
D4321	Provisional Splinting, Extracoronal	56.50	N/A
D4341	Periodontal Scaling and Root Planing – 4+ Teeth, Per Quadrant	122.00	N/A
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth, Per Quadrant	77.00	N/A
D4910	Periodontal Maintenance Procedure	67.00	N/A
D5110	Complete Denture - Maxillary	376.35	376.35
D5120	Complete Denture - Mandibular	376.35	376.35
D5130	Immediate Denture – Maxillary	376.35	376.35
D5140	Immediate Denture – Mandibular	376.35	376.35
D5211	Maxillary Partial Denture — Resin Base	357.55	N/A
D5212	Mandibular Partial Denture — Resin Base	357.55	N/A
D5213	Maxillary Partial Denture — Cast Metal Framework	366.95	N/A
D5214	Mandibular Partial Denture — Cast Metal Framework	366.95	N/A
D5510	Repair Complete Denture Base	61.15	61.15
D5520	Replace Missing or Broken Teeth, Complete Denture	38.10	38.10
D5610	Repair Partial Denture Base	51.75	51.75

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D5620	Repair Cast Framework	79.05	79.05
D5630	Repair or Replace Broken Clasp	71.50	71.50
D5640	Replace Broken Teeth, Each Additional Tooth	37.65	37.65
D5650	Add Tooth to Existing Partial	42.35	42.35
D5730	Reline Complete Maxillary Denture, Chairside	70.60	70.60
D5731	Reline Complete Mandibular Denture, Chairside	70.60	70.60
D5740	Reline Maxillary Partial Denture, Chairside	70.60	70.60
D5741	Reline Mandibular Partial Denture, Chairside	70.60	70.60
D5750	Reline Complete Maxillary Denture, Laboratory	117.60	117.60
D5751	Reline Complete Mandibular Denture, Laboratory	117.60	117.60
D5760	Reline Maxillary Partial Denture, Laboratory	117.60	117.60
D5761	Reline Mandibular Partial Denture, Laboratory	117.60	117.60
D5911	Facial Moulage-sectional	By Report	By Report
D5912	Facial Moulage-complete	By Report	By Report
D5913	Nasal Prosthesis	By Report	By Report
D5914	Auricular Prosthesis	By Report	By Report
D5915	Orbital Prosthesis	By Report	By Report
D5916	Ocular Prosthesis	By Report	By Report
D5919	Facial Prosthesis	By Report	By Report
D5922	Nasal Septal Prosthesis	By Report	By Report
D5923	Ocular Prosthesis, interim	By Report	By Report
D5924	Cranial Prosthesis	By Report	By Report
D5925	Facial Augmentation implant Prosthesis	By Report	By Report
D5926	Nasal Prosthesis, replacement	By Report	By Report
D5927	Auricular Prosthesis, replacement	By Report	By Report
D5928	Orbital Prosthesis, replacement	By Report	By Report
D5929	Facial Prosthesis, replacement	By Report	By Report
D5931	Obturator Prosthesis, surgical	By Report	By Report
D5932	Obturator Prosthesis, definitive	By Report	By Report
D5933	Obturator Prosthesis, modification	By Report	By Report
D5934	Mandibular Resection Prosthesis with guide flanges	By Report	By Report
D5935	Mandibular Resection Prosthesis without guide flanges	By Report	By Report
D5936	Obturator Prosthesis, interim	By Report	By Report
D5937	Trismus Appliance	By Report	By Report
D5951	Feeding Aid	By Report	By Report
D5952	Speech Aid Prosthesis, pediatric	By Report	N/A
D5953	Speech Aid Prosthesis, adult	By Report	By Report
D5954	Palatal Augmentation, Prosthesis	By Report	By Report
D5955	Palatal Lift Prosthesis, definitive	By Report	By Report
D5958	Palatal Lift Prosthesis, Interim	By Report	By Report
D5959	Palatal Lift Prosthesis, modification	By Report	By Report
D5960	Speech Aid Prosthesis, modification	By Report	By Report
D5982	Surgical Stent	By Report	By Report
D5983	Radiation Carrier	By Report	By Report
D5984	Radiation Shield	By Report	By Report
D5985	Radiation Cone Locator	By Report	By Report
D5986	Fluoride Gel Carrier	By Report	By Report
D5987	Commissure Splint	By Report	By Report
D5988	Surgical Splint	By Report	By Report
D5999	Unspecified Maxillofacial Prosthesis	By Report	By Report

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D6210	Pontic crown – metal high noble	178.80	N/A
D6211	Pontic crown – metal base	178.80	N/A
D6212	Pontic crown – metal noble	178.80	N/A
D6240	Pontic crown – porc/metal high noble	178.80	N/A
D6241	Pontic crown - porc/base Metal	178.80	N/A
D6242	Pontic crown – porc metal noble	178.80	N/A
D6251	Pontic-Resin/Base Metal	103.50	N/A
D6721	Crown-Resin/Predominately Base Metal	136.40	N/A
D6750	Crown – porc/metal high noble	159.95	N/A
D6751	Crown-Porcelain/Predominately Base Metal	159.95	N/A
D6752	Crown – porc/metal noble	159.95	N/A
D6790	Crown – full metal high noble	159.95	N/A
D6791	Crown - full metal base	159.95	N/A
D6792	Crown - full metal noble	159.95	N/A
D6930	Recement Fixed Partial Denture	32.90	32.90
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	26.35	N/A
D6999	Unspecified, fixed prosthodontic procedure, by report	By Report	By Report
D7140	Extraction – Erupted Tooth or Exposed Root	39.12	39.12
D7210	Surgical Removal of Erupted Tooth	57.40	57.40
D7220	Removal of Impacted Tooth — Soft Tissue	66.80	66.80
D7230	Removal for Impacted Tooth — Partially Bony	86.60	86.60
D7240	Removal of Impacted Tooth — Completely Bony	100.70	100.70
D7250	Surgical Removal of Residual Roots	57.40	57.40
D7280	Surgical access of unerupted tooth	50.80	N/A
D7283	Placement of device to facilitate eruption of impacted tooth	45.00	N/A
D7310	Alveoloplasty in Conjunction with Extractions — per quadrant	64.00	N/A
D7311	Alveoloplasty w/ extraction – 1-3 teeth/spaces per quad	64.00	N/A
D7320	Alveoloplasty Not in Conjunction With Extractions — per quadrant	64.00	N/A
D7321	Alveoloplasty w/o extractions – 1- 3 teeth/spaces per quad	64.00	N/A
D7450	Removal of Odontogenic Cyst or Tumor up to 1.25cm	94.30	94.30
D7451	Removal of Odontogenic Cyst orTumor over 1.25cm	199.60	199.60
D7460	Removal of Non-Odontogenic Cyst or Tumor up to 1.25cm	94.30	94.30
D7461	Removal of Non-Odontogenic Cyst or Tumor over 1.25cm	199.60	199.60
D7510	Incision and Drainage Abscess	36.70	36.70
D7511	Incision & drainage – intraoral - complicated	36.70	36.70
D7610	Maxilla Open Reduction, Teeth Immobilized	657.95	657.95
D7620	Maxilla Closed Reduction, Teeth Immobilized	471.50	471.50
D7630	Mandible-Open Reduction, Teeth Immobilized	824.65	824.65
D7640	Mandible-Closed Reduction, Teeth Immobilized	706.95	706.95
D7710	Maxilla-Open Reduction	1059.35	1059.35
D7720	Maxilla-Closed Reduction	706.35	706.35
D7730	Mandible-Open Reduction	1059.35	1059.35
D7740	Mandible-Closed Reduction	706.20	706.20
D7810	Open Reduction of Dislocation	438.60	438.60
D7820	Closed Reduction of Dislocation	177.65	177.65
D7960	Frenulectomy-Separate Procedure (frenectomy or frenotomy)	77.15	N/A
D7963	Frenuloplasty	77.15	N/A
D7999	Unspecified Oral Surgery Procedure	By Report	By Report
D8080	Initial Orthodontic Appliance Placement	900.00	N/A
D8660	Initial Examination, Records, Radiographs & Facial Photographs	100.00	N/A
D8670	Monthly Adjustments	110.00	N/A
D8680	Removal of Appliances, Construction, and Placement of Retainers	150.00	N/A
D8999	Initial Orthodontic Evaluation/Study Models	47.05	N/A

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Procedure Code	Procedure	Maximum Allowance Children	Maximum Allowance Adults
D9110	Palliative (emergency) Treatment of Dental Pain-Minor Procedures	55.00	55.00
D9220	General Anesthesia – Require Dental Sedation Permit B to bill	76.70	76.70
D9221	General Anesthesia – each additional 15 minutes	38.35	38.35
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	26.00	26.00
D9241	Intravenous Sedation – Require Dental Sedation Permit A to bill	76.70	76.70
D9242	Intravenous Sedation – Each additional 15 minutes	38.35	38.35
D9248	Non-intravenous conscious sedation – Require Dental Sedation Permit A to bill	48.00	48.00
D9310	Consultation	17.10	17.10
D9610	Therapeutic Drug Injection	By Report	By Report
D9630	Other Drugs and Medicaments	23.50	23.50
D9999	Unspecified Procedure, By Report	By Report	By Report

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ATTACHMENT Z

HFS DENTAL PROGRAM/ALL KIDS PROGRAM
DENTAL VISIT CO-PAYMENTS

	All Kids Previously called Kid Care			Expanded Coverage Under All Kids/HFS Dental Program							
Dental Visit Types	**All Kids Assist**	**All Kids Share**	**All Kids Premium Level 1**	**All Kids Premium Level 2**	**All Kids Premium Level 3**	**All Kids Premium Level 4**	**All Kids Premium Level 5**	**All Kids Premium Level 6**	**All Kids Premium Level 7**	**All Kids Premium Level 8**
Preventive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Diagnostic	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Restorative	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Endodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Peridontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Prosthodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Oral and Maxillofacial Surgery	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Orthodontics	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25
Adjunctive Services	N/A	$2	$5	$10	$15	$20	$25	$25	$25	$25

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health. For children entering or in kindergarten, second grade, and sixth grade, completion of a mandated IDPH Proof of School Dental Examination form is considered part of the oral exmination. Providers must complete the exam form free of charge if reqested by the parent or guardian within six (6) months of the oral examination.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if Doral determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. Doral utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment K of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic examination is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) examination is used when evaluating a child comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

OUT-OF-OFFICE SERVICES: Providers who render preventive exams in an out-of-office setting must check the "Other" box on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the "Provider's Office" or "ECF" box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate.

Dental Providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleanings and fluoride treatment. Each provider must provide any follow-up sealants in addition to the exam, cleaning and fluoride treatment when needed.

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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation	0 - 20		No	One per 6 Month(s) Per Patient. Participants are also eligible for one periodic oral evaluation (D0120) performed in school setting per 12 months. Completion of a mandated school exam form is considered part of the oral examination	Place of service.
D0140	limited oral evaluation-problem focused	0 - 20		No	Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding or traumatic injury. Not allowed with D9110.	Description of the emergency and description of services provided with claim.
D0150	comprehensive oral evaluation	0 - 20		No	One per 1 Lifetime Per Patient per (Provider or Location).	
D0210	intraoral-complete series (including bitewings)	6 - 20		No	One per 36 Month(s) Per Patient per (Provider or Location). One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location).	
D0220	intraoral-periapical-1st film	0 - 20		No	One per 1 Day(s) Per Patient per (Provider or Location).	
D0230	intraoral-periapical-each additional film	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single film	0 - 20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two films	2 - 20		No	One per 12 Month(s) Per Patient per (Provider or Location). One of (D0272, D0274) per 12 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0274	bitewings - four films	10 - 20		No	One per 12 Month(s) Per Patient per (Provider or Location). One of (D0272, D0274) per 12 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	

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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	One per 36 Month(s) Per Patient per (Provider or Location). One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0330	panoramic film	6 - 20		No	One per 36 Month(s) Per Patient per (Provider or Location). One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy for Participants age 0 through 20. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once every 6 months. Prophylaxis includes necessary scaling and polishing.

The topical application of fluoride treatment is allowed once every 12 months for Participants age 0 through 20.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

Space maintainers are a covered service for Participants age 1 through 20 when determined by a Doral Consultant to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

OUT-OF-OFFICE SERVICES: Providers who render preventive services in an out-of-office setting must check the "Other" box on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the “Provider’s Office” or “ECF” box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate.

Dental providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning and fluoride treatment. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed.

Preventive						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1120	prophylaxis - child	0 - 20		No	One per 6 Month(s) Per Patient. Removal of plaque, calculus and stains from the tooth surfaces. Intended to control local irrational factors.	Place of service.
D1203	topical application of fluoride (prophylaxis not included) - child	0 - 20		No	One per 12 Month(s) Per Patient. One per 12 months per patient in an office setting. One per 12 months per patient in an school setting. Prescription strength fluoride delivered to the dentition under the direct supervision of a dental professional.	Place of service.

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Preventive						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1206	topical flouride varnish	0 - 2		No	One per 12 Month(s) Per Patient. Three times per 12 months per patient in an office setting. One per 12 months per patient in a school setting. Prescription strength fluoride delivered to the dentition under the direct supervision of a dental professional.	Place of service.
D1206	topical flouride varnish	3 - 20		No	One per 12 Month(s) Per Patient. One per 12 months per patient in an office setting. One per 12 months per patient in an school setting. Prescription strength fluoride delivered to the dentition under the direct supervision of a dental professional.	Place of service.
D1351	sealant - per tooth	5 - 17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One per 1 Lifetime Per Patient. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1510	space maintainer-fixed-unilateral	0 - 20	Per Quadrant (LL, LR, UL, UR)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1515	space maint-fixed-bilateral	0 - 20	Per Arch (LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1520	space maintainer-removable-unilateral	0 - 20	Per Quadrant (LL, LR, UL, UR)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1525	space maintainer-removable-bilateral	0 - 20	Per Arch (LA, UA)	No	Covered when indicated due to premature loss of posterior primary teeth.	Pre-operative radiographs.
D1550	recementation space maintainer	1 - 20		No		

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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		
D2150	Amalgam - two surfaces, primary or permanent	0 - 20	Teeth 1 - 32, A - T	No		
D2160	Amalgam - three surface, primary or permanent	0 - 20	Teeth 1 - 32, A - T	No		
D2161	Amalgam - four surfaces, primary or permanent	0 - 20	Teeth 1 - 32, A - T	No		
D2330	resin-1 surface, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2331	resin-2 surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2332	resin-3 surfaces, anterior	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - 1 surface, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure.	
D2392	resin-based composite - 2 surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No		
D2393	resin-based composite - 3 surfaces, posterior	0 - 20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No		
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		
D2740	crown-porcelain/ceramic substrate	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient.	Pre-operative radiographs.

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2750	crown-porcelain fused to high noble	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2751	crown-porcelain fused to metal	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2752	crown-porcelain fused noble metal	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2790	crown-full cast high noble	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2791	crown - full cast base metal	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2792	crown - full cast noble metal	0 - 20	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2910	recement inlay	0 - 20	Teeth 1 - 32	No		
D2915	recement cast or prefabricated post and core	0 - 20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (prefabricated post and core in addition to crown) by same provider or provider group.	
D2920	recement crown	0 - 20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or provider group.	
D2930	prefabricated steel crown - primary tooth	0 - 20	Teeth A - T	No		
D2931	prefabricated steel crown-permanent tooth	0 - 20	Teeth 1 - 32	Yes	Authorization required for three or more crowns. Not compensated with construction of permanent crown.	Pre-operative radiographs.
D2932	prefabricated resin crown	0 - 20	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	Authorization required for three (3) or more crowns.	Pre-operative radiographs.

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2933	prefabricated steel crown with resin window	0 - 20	Teeth C - H, M - R	No		
D2940	sedative filling	0 - 20	Teeth 1 - 32, A - T	No	Not allowed with any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services.)	
D2950	core buildup, including any pins	0 - 20	Teeth 1 - 32	No	Only covered after a root canal has been performed on the same tooth.	
D2951	pin retention - per tooth in addition to restoration	0 - 20	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	0 - 20	Teeth 1 - 32	Yes		Endodontic fill radiograph.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Doral's treatment standards, Doral can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Doral Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration)	0 - 20	Teeth A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth	0 - 20	Teeth C - H, M - R	No		
D3310	Endodontic therapy, anterior (exc final rest)	1 - 20	Teeth 6 - 11, 22 - 27	No	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	
D3320	Endodontic therapy, bicuspid (exc final restore)	1 - 20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	
D3330	Endodontic therapy, molar(excluding final restore)	1 - 20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	
D3351	apexification/recalcification - initial visit	1 - 20	Teeth 1 - 32	Yes	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	Pre-operative radiographs.

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3352	apexification/recalcification - interim medication replacement	1 - 20	Teeth 1 - 32	Yes	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	Pre-operative radiograph with claim.
D3353	apexification/recalcification - final visit	1 - 20	Teeth 1 - 32	Yes	One per 1 Lifetime Per Patient. One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per Patient.	Pre-operative radiograph and fill radiograph with claim.
D3410	apicoectomy/periradicular surgery - anterior	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 1 Lifetime Per Patient. Not payable concurrently with root canal treatment of tooth.	Pre-operative radiographs.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4211	gingivectomy or gingivoplasty, per tooth	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4240	gingival flap procedure, including root planing - per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4241	gingival flap procedure, including root planing - 1-3 teeth, per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4260	osseous surgery (including flap entry and closure) - per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4261	osseous surgery (including flap entry and closure) - 1-3 teeth, per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4260, D4241, D4261) per 24 Month(s) Per Patient per (Provider or Location).	Pre-operative radiographs and periodontal charting.
D4263	bone replacement graft-1st quadrant site	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4264	bone replacement graft - each additional site in quadrant	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4270	pedicle soft tissue graft procedure	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4271	free soft tissue graft procedure	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4273	subepithelial connective tissue graft procedure	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4274	distal or proximal wedge procedure	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs and periodontal charting.
D4320	provision splinting - intracoronal	0 - 20	Per Arch (LA, UA)	Yes		Pre-operative radiographs and periodontal charting.

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4321	provision splinting - extracoronal	0 - 20	Per Arch (LA, UA)	Yes		Pre-operative radiographs and periodontal charting.
D4341	periodontal scaling and root planing, per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 24 Month(s) Per Patient. One full mouth service is covered every 24 months.	Pre-operative radiographs and periodontal charting.
D4342	periodontal scaling and root planing - 1-3 teeth, per quadrant	0 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 24 Month(s) Per Patient. One full mouth service is covered every 24 months.	Pre-operative radiographs and periodontal charting.
D4910	periodontal maintenance procedures	0 - 20		Yes	Only covered after active therapy has been performed.	Pre-operative radiographs and periodontal charting.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

Removable Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5110, D5130) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5120	complete denture - mandibular	0 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5120, D5140) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5130	immediate denture - maxillary	0 - 20		Yes	One per 1 Lifetime Per Patient. One of (D5110, D5130) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs.
D5140	immediate denture - mandibular	0 - 20		Yes	One per 1 Lifetime Per Patient. One of (D5120, D5140) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs.
D5211	maxillary partial denture-resin base	1 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5211, D5213) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).

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Removable Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture-resin base	1 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5212, D5214) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5213	maxillary part denture - cast metal framework with resin bases	1 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5211, D5213) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5214	mandibular partial denture - cast metal framework with resin bases	1 - 20		Yes	One per 60 Month(s) Per Patient. One of (D5212, D5214) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs. Date of prior placement (if applicable).
D5510	repair broken complete denture base	0 - 20	Per Arch (LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0 - 20	Teeth 1 - 32	No		
D5610	repair resin denture base	0 - 20	Per Arch (LA, UA)	No		
D5620	repair cast framework	0 - 20	Per Arch (LA, UA)	No		
D5630	repair or replace broken clasp	0 - 20		No		
D5640	replace broken teeth-per tooth	0 - 20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0 - 20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chair)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5731	reline complete mandibular denture (chair)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.
D5740	reline maxillary partial denture(chair)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5741	reline mandibular partial denture (chair)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.
D5750	reline complete maxillary denture (laboratory)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5751	reline complete mandibular denture (laboratory)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.

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Removable Prosthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5761	reline mandibular partial denture (laboratory)	0 - 20		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0 - 20		Yes		Narrative of medical necessity.
D5912	facial moulage (complete)	0 - 20		Yes		Narrative of medical necessity.
D5913	nasal prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5914	auricular prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5915	orbital prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5916	ocular prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5919	facial prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5922	nasal septal prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5923	ocular prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5924	cranial prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5925	facial augment implant prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5926	nasal prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.
D5927	auricular prosthesis, replace	0 - 20		Yes		Narrative of medical necessity.
D5928	orbital prosthesis, replace	0 - 20		Yes		Narrative of medical necessity.
D5929	facial prosthesis, replacement	0 - 20		Yes		Narrative of medical necessity.
D5931	obturator prosthesis, surgical	0 - 20		Yes		Narrative of medical necessity.
D5932	obturator prosthesis, definitive	0 - 20		Yes		Narrative of medical necessity.
D5933	obturator prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.
D5934	mandibular resection prosthesis with guide flange	0 - 20		Yes		Narrative of medical necessity.
D5935	mandibular resection prosthesis without guide flange	0 - 20		Yes		Narrative of medical necessity.
D5936	obturator prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5937	trismus appliance (not for TMD treatment)	0 - 20		Yes	Not for TMD Treatment.	Narrative of medical necessity.
D5951	feeding aid	0 - 20		Yes		Narrative of medical necessity.

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5952	speech aid prosthesis, pediatric	0 - 12		Yes		Narrative of medical necessity.
D5953	speech aid prosthesis, adult	13 - 20		Yes		Narrative of medical necessity.
D5954	palatal augment prosthesis	0 - 20		Yes		Narrative of medical necessity.
D5955	palatal lift prosthesis, definitive	0 - 20		Yes		Narrative of medical necessity.
D5958	palatal lift prosthesis, interim	0 - 20		Yes		Narrative of medical necessity.
D5959	palatal lift prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.
D5960	speech aid prosthesis, modification	0 - 20		Yes		Narrative of medical necessity.
D5982	surgical stent	0 - 20		Yes		Narrative of medical necessity.
D5983	radiation carrier	0 - 20		Yes		Narrative of medical necessity.
D5984	radiation shield	0 - 20		Yes		Narrative of medical necessity.
D5985	radiation cone locator	0 - 20		Yes		Narrative of medical necessity.
D5986	fluoride gel carrier	0 - 20		Yes		Narrative of medical necessity.
D5987	commissure splint	0 - 20		Yes		Narrative of medical necessity.
D5988	surgical splint	0 - 20		Yes		Narrative of medical necessity.
D5999	unspecified maxillofacial prosthesis, by report	0 - 20		Yes		Narrative of medical necessity.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

Fixed Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6211	pontic-cast base metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6212	pontic - cast noble metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6240	pontic-porcelain fused-high noble	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6241	pontic-porcelain fused metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).

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Fixed Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6242	pontic-porcelain fused-noble metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6251	pontic-resin with base metal	1 - 20	Teeth 6 - 11, 22 - 27	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6721	crown-resin with base metal	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6750	crown-porce fused high noble	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6751	crown-porcelain fused to metal	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6752	crown-porce fused noble metal	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6790	crown-full cast high noble	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6791	crown - full cast base metal	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).

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Fixed Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6792	crown - full cast noble metal	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One per 60 Month(s) Per Patient. One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Pre-operative radiographs. Date of prior placement (if applicable).
D6930	recement fixed partial denture	0 - 20		No	Not billable by same provider or provider group within 6 months of placement.	
D6972	prefabricated post and core + retainer	1 - 20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6250, D6251, D6252, D6720, D6721, D6722, D6751, D6752, D6780, D6790, D6791, D6792, D6970, D6972, D6794) per 60 Month(s) Per Patient.	Endodontic fill radiograph.
D6999	fixed prosthodontic procedure	0 - 20	Teeth 1 - 32	Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

PROVIDERS BILLING ANESTHESIA SERVICES WITH ORAL SURGERY SERVICES MUST HAVE THE APPROPRIATE PERMITS IN ORDER TO BE REIMBURSED FOR SEDATION. SEE ANESTHESIA CODES FOR FURTHER DETAIL (D9220 - D9248).

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	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	1 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth from pathology is not a covered benefit.	Pre-operative radiographs.
D7230	removal of impacted tooth-partially bony	1 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth from pathology is not a covered benefit.	Pre-operative radiographs.
D7240	removal of impacted tooth-completely bony	1 - 20	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth from pathology is not a covered benefit.	Pre-operative radiographs.
D7250	surgical removal of residual tooth roots	1 - 20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7280	surgical exposure of impacted or unerupted tooth for orthodontic reasons	1 - 20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted.	Pre-operative radiographs.
D7283	placement of device to facilitate eruption of impacted tooth	1 - 20	Teeth 1 - 32	Yes	One per 1 Lifetime Per Patient. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	Pre-operative radiographs. For ortho cases only.
D7310	alveoloplasty in conjunction with extractions per quadrant	1 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 1 Lifetime Per Patient. One of (D7310, D7311) per 60 Month(s) Per Patient.	Pre-operative radiographs.
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 1 Lifetime Per Patient. One of (D7310, D7311) per 60 Month(s) Per Patient.	Pre-operative radiographs.
D7320	alveoloplasty not in conjunction with extractions - per quadrant	1 - 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 1 Lifetime Per Patient. One of (D7320, D7321) per 1 Lifetime Per Patient.	Diagnostic models.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	1- 20	Per Quadrant (LL, LR, UL, UR)	Yes	One per 1 Lifetime Per Patient. One of (D7320, D7321) per 1 Lifetime Per Patient.	Diagnostic models.
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0 - 20		Yes		Copy of pathology report with claim.
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0 - 20		Yes		Copy of pathology report with claim.
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0 - 20		Yes		Copy of pathology report with claim.
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0 - 20		Yes		Copy of pathology report with claim.
D7510	incision and drainage of abscess - intraoral soft tissue	0 - 20		Yes	One of (D7510, D7511) per 1 Day(s) Per Patient. Either D7510 or D7511 on date of service. Not allowed on same date of service as D7140-D7250 (extractions).	Pre-operative radiographs and narrative with claim.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0 - 20		Yes	One of (D7510, D7511) per 1 Day(s) Per Patient. Either D7510 or D7511 on date of service.	Pre-operative radiographs and narrative with claim.
D7610	maxilla - open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.

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Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7620	maxilla - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7630	mandible-open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7640	mandible - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7710	maxilla - open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7720	maxilla - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7730	mandible - open reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7740	mandible - closed reduction	0 - 20		Yes		Pre-operative radiographs and accident narrative details with claim.
D7810	open reduction of dislocation	0 - 20		Yes		Narrative of medical necessity with claim.
D7820	closed reduction dislocation	0 - 20		Yes		Narrative of medical necessity with claim.
D7960	frenulectomy-separate procedure	1 - 20		Yes	One per 1 Lifetime Per Patient. One of (D7960, D7963) per 1 Lifetime Per Patient.	Narrative of medical necessity. Study model or photo.
D7963	frenuloplasty	1 - 20		Yes	One per 1 Lifetime Per Patient. One of (D7960, D7963) per 1 Lifetime Per Patient.	Narrative of medical necessity. Study model or photo.
D7999	unspecified oral surgery procedure, by report	0 - 20		Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. PARTICIPANTS MUST HAVE A SEVERE, DYSFUNCTIONAL, HANDICAPPING MALOCCLUSION AS DETERMINED BY A SCORE OF 42 POINTS OR GREATER ON THE MODIFIED SALZMANN INDEX, OR OBJECTIVE DOCUMENTATION THAT THE MALOCCLUSION IS AN IMPAIRMENT OF, OR A HAZARD TO THE ABILITY TO EAT, CHEW, SPEAK, OR BREATHE. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. INTERCEPTIVE ORTHODONTICS IS NOT A COVERED BENEFIT. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. THE PARTICIPANT MUST HAVE LOST ALL PRIMARY TEETH AND HAVE PERMANENT TEETH ERUPTING OR IN OCCLUSION TO BE CONSIDERED.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1.800.322.3722.

All orthodontic services require prior authorization by a Doral Dental Consultant. Requests for prior authorization must include:

* Orthodontic examination and records
* Appropriate radiographs and facial photographs
* Study models properly trimmed and identified
* Detailed treatment plan with diagnosis and prognosis

The charge for the initial exam, radiographs and study models should be submitted under procedure code D8660.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). IN ORDER TO RECEIVE REIMBURSEMENT FOR MONTHLY ADJUSTMENTS, PROVIDER MUST BILL FOR EACH DATE OF SERVICE TREATMENT WAS RENDERED. Only one D8670 allowed per calendar month and 24 D8670's allowed per case per lifetime. If a Participant fails to keep an appointment for two consecutive months, the dental office must notify Doral.

Continuation of orthodontic care will be handled as follows:

1. For cases that were started prior to the date the Participant was enrolled in the Medical Assistance program, Doral will attempt to secure the original pre-treatment records for review by a Doral Dental Consultant. The Modified Salzmann Index will be performed and the original records reviewed using the criteria for all new cases. If the original records pass the test of medical necessity, a continuation of benefits based on a proration of the remaining treatment will be authorized.

2. For cases that were started under the Medical Assistance Program, a Participant will be allowed to transfer treatment only under extreme situations. Usually this will be limited to when a Participant moves out of the immediate service area. In this instance, the dentist who will complete the treatment must submit a claim form indicating the treatment status of the case, his/her intention to continue care and a charge for the remaining treatment. Doral will review the request on a case by case basis and issue a determination of benefits.

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8080	comprehensive orthodontic treatment of the adolescent dentition	1 - 20		Yes	One per 1 Lifetime Per Patient.	Study models (or OrthoCad equivalent) and radiographs.
D8660	pre-orthodontic treatment visit	1 - 20		Yes		Study models (or OrthoCad equivalent) and radiographs.
D8670	periodic orthodontic treatment visit (as part of contract)	1 - 20		Yes	One per 1 Month(s) Per Patient. Maximum of 1 per month regardless of number of visits per month.	
D8680	orthodontic retention (removal of appliances)	1 - 20		Yes	One per 1 Lifetime Per Patient.	Date of debanding with claim form.
D8999	unspecified orthodontic procedure, by report	1 - 20		Yes	One per 1 Lifetime Per Patient. Only covered if case fails to reach 42 points on the Modified Salzman Index.	

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Exhibit AA: Benefits Covered - CHILDREN UNDER AGE 21

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolledbehaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. Doral or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

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IN ACCORDANCE WITH THE ILLINOIS DENTAL PRACTICE ACT AS DEFINED IN THE ILLINOIS ADMINISTRATIVE CODE 1220.500, PROCEDURE CODES D9241 AND D9248 REQUIRE A DENTAL SEDATION PERMIT A OR DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

PROCEDURE CODE D9220 REQUIRES AN DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

Adjunctive General						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0 - 20		No	Not covered with D0140 on same date of service.	
D9220	general anesthesia - first 30 minutes	0 - 20		Yes	Not allowed on same date of service as D9230, D9241, D9242 or D9248.	Narrative of medical necessity.
D9221	general anesthesia - each additional 15 minutes	0 - 20		Yes	Four per 1 Day(s) Per Patient. Not allowed on same date of service as D9230, D9241, D9242 or D9248.	Narrative of medical necessity.
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	0 - 20		No	Not allowed on same date of service as D9220, D9221, D9241, D9242 or D9248.	Medical necessity must be documented in the patient's treatment record.
D9241	intravenous sedation/analgesia - first 30 minutes	0 - 20		Yes	Not allowed on same date of service as D9220, D9221, D9230 or D9248.	Narrative of medical necessity.
D9242	intravenous sedation/analgesia - each additional 15 minutes	0 - 20		Yes	Four per 1 Day(s) Per Patient. Not allowed on same date of service as D9220, D9221, D9230 or D9248.	Narrative of medical necessity.
D9248	non-intravenous conscious sedation	0 - 20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Not allowed on the same date of service as D9220, D9221, D9230, D9241 or D9242.	Provider must possess a Class A or Class B anesthesia permit.
D9310	consultation	0 - 20		No		Narrative of medical necessity shall be maintained in patient records.
D9610	therapeutic drug injection, by report	0 - 20		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9630	other drugs and/or medicaments, by report	0 - 20		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9999	unspecified adjunctive procedure, by report	0 - 20		Yes		Description of service and narrative of medical necessity.

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health. Periodic exams are not a covered benefit for Participants age 21 and over.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if Doral determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. Doral utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment K of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	21 and older		No	Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with D9110	Description of the emergency and description of services provided with claim.
D0150	comprehensive oral evaluation	21 and older		No	One per 1 Lifetime Per Patient per (Provider or Location).	
D0210	intraoral-complete series (including bitewings)	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location).	
D0220	intraoral-periapical-1st film	21 and older		No	One per 1 Day(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0230	intraoral-periapical-each additional film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0270	bitewing - single film	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to	

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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two films	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0274	bitewings - four films	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0330	panoramic film	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per Patient per (Provider or Location). Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Repeated unexplained failures will result in review by Peer Review and may result in a referral to the Illinois Office of the Inspector General for additional investigation.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No		
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No		
D2160	Amalgam - three surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No		
D2161	Amalgam - four surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No		
D2330	resin-1 surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2331	resin-2 surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2332	resin-3 surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2335	resin-4+ surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - 1 surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure.	
D2392	resin-based composite - 2 surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No		
D2393	resin-based composite - 3 surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No		
D2394	resin-based composite - 4 or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No		
D2740	crown-porcelain/ceramic substrate	21 and older	Teeth 1 - 32	Yes	One per 60 Month(s) Per Patient. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient.	Pre-operative radiographs.

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2750	crown-porcelain fused to high noble	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2751	crown-porcelain fused to metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2752	crown-porcelain fused noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2790	crown-full cast high noble	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2791	crown - full cast base metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792) per 60 Month(s) Per Patient. Per tooth.	Pre-operative radiographs.
D2910	recement inlay	21 and older	Teeth 1 - 32	No		
D2915	recement cast or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (prefabricated post and core in addition to crown) by same provider or provider group.	
D2920	recement crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or provider group.	
D2931	prefabricated steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	Pre-operative radiographs.
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	Authorization required for two (2) or more crowns.	Pre-operative radiographs.
D2940	sedative filling	21 and older	Teeth 1 - 32, A - T	No	Not allowed with any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services.)	
D2950	core buildup, including any pins	21 and older	Teeth 1 - 32	No	Only covered after a root canal has been performed on the same tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth in addition to restoration	21 and older	Teeth 1 - 32	No		
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes		Endodontic fill radiograph.

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet Doral's treatment standards, Doral can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Doral Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

* Root resorption has started and exfoliation is imminent
* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
* The general oral condition does not justify root canal therapy due to the loss of arch integrity
* Tooth does not demonstrate 50% bone support
* Tooth demonstrates active untreated periodontal disease

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3310	Endodontic therapy, anterior (exc final rest)	21 and older	Teeth 6 - 11, 22 - 27	No	One per 1 Lifetime Per Patient.	

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Provisions for removable prosthesis included initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

* Patients on feeding tubes
* Post CVA patients with decreased facial muscle tone
* Patients in a coma
* Patients with diminished mental capacities that could not function with dentures
* Patients who do not desire dentures
* Advanced terminal patients

Removable Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	One per 60 Month(s) Per Patient. One of (D5110, D5130) per 60 Month(s) Per Patient.	
D5120	complete denture - mandibular	21 and older		Yes	One per 60 Month(s) Per Patient. One of (D5120, D5140) per 60 Month(s) Per Patient.	
D5130	immediate denture - maxillary	21 and older		Yes	One per 1 Lifetime Per Patient. One of (D5110, D5130) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs.
D5140	immediate denture - mandibular	21 and older		Yes	One per 1 Lifetime Per Patient. One of (D5120, D5140) per 60 Month(s) Per Patient.	Pre-operative full mouth radiographs.
D5510	repair broken complete denture base	21 and older	Per Arch (LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5610	repair resin denture base	21 and older	Per Arch (LA, UA)	No		

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Removable Prosthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5620	repair cast framework	21 and older	Per Arch (LA, UA)	No		
D5630	repair or replace broken clasp	21 and older		No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chair)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5731	reline complete mandibular denture (chair)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.
D5740	reline maxillary partial denture(chair)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5741	reline mandibular partial denture (chair)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5730, D5740, D5750, D5760) per 24 Month(s) Per Patient.	Date of denture placement.
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One per 24 Month(s) Per Patient. One of (D5731, D5741, D5751, D5761) per 24 Month(s) Per Patient.	Date of denture placement.

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5911	facial moulage (sectional)	21 and older		Yes		Narrative of medical necessity.
D5912	facial moulage (complete)	21 and older		Yes		Narrative of medical necessity.
D5913	nasal prosthesis	21 and older		Yes		Narrative of medical necessity.
D5914	auricular prosthesis	21 and older		Yes		Narrative of medical necessity.
D5915	orbital prosthesis	21 and older		Yes		Narrative of medical necessity.
D5916	ocular prosthesis	21 and older		Yes		Narrative of medical necessity.
D5919	facial prosthesis	21 and older		Yes		Narrative of medical necessity.
D5922	nasal septal prosthesis	21 and older		Yes		Narrative of medical necessity.
D5923	ocular prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5924	cranial prosthesis	21 and older		Yes		Narrative of medical necessity.
D5925	facial augment implant prosthesis	21 and older		Yes		Narrative of medical necessity.
D5926	nasal prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.
D5927	auricular prosthesis, replace	21 and older		Yes		Narrative of medical necessity.
D5928	orbital prosthesis, replace	21 and older		Yes		Narrative of medical necessity.
D5929	facial prosthesis, replacement	21 and older		Yes		Narrative of medical necessity.
D5931	obturator prosthesis, surgical	21 and older		Yes		Narrative of medical necessity.
D5932	obturator prosthesis, definitive	21 and older		Yes		Narrative of medical necessity.
D5933	obturator prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		Narrative of medical necessity.
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		Narrative of medical necessity.
D5936	obturator prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	Narrative of medical necessity.

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Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5951	feeding aid	21 and older		Yes		Narrative of medical necessity.
D5953	speech aid prosthesis, adult	21 and older		Yes		Narrative of medical necessity.
D5954	palatal augment prosthesis	21 and older		Yes		Narrative of medical necessity.
D5955	palatal lift prosthesis, definitive	21 and older		Yes		Narrative of medical necessity.
D5958	palatal lift prosthesis, interim	21 and older		Yes		Narrative of medical necessity.
D5959	palatal lift prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5960	speech aid prosthesis, modification	21 and older		Yes		Narrative of medical necessity.
D5982	surgical stent	21 and older		Yes		Narrative of medical necessity.
D5983	radiation carrier	21 and older		Yes		Narrative of medical necessity.
D5984	radiation shield	21 and older		Yes		Narrative of medical necessity.
D5985	radiation cone locator	21 and older		Yes		Narrative of medical necessity.
D5986	fluoride gel carrier	21 and older		Yes		Narrative of medical necessity.
D5987	commissure splint	21 and older		Yes		Narrative of medical necessity.
D5988	surgical splint	21 and older		Yes		Narrative of medical necessity.
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		Narrative of medical necessity.

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Fixed Prosthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6930	recement fixed partial denture	21 and older		No	Not billable by same provider or provider group within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

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Exhibit BB: Benefits Covered - ADULTS - AGE 21 AND OVER

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

“Erupted surgical extractions” are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review. Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

PROVIDERS BILLING ANESTHESIA SERVICES WITH ORAL SURGERY SERVICES MUST HAVE THE APPROPRIATE PERMITS IN ORDER TO BE REIMBURSED FOR SEDATION. SEE ANESTHESIA CODES FOR FURTHER DETAIL (D9220 - D9248).

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	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.

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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	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	Pre-operative radiographs.
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Copy of pathology report with claim.
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Copy of pathology report with claim.
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Copy of pathology report with claim.
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Copy of pathology report with claim.
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per Patient. Either D7510 or D7511 on date of service. Not allowed on same date of service as D7140-D7250 (extractions).	Pre-operative radiographs and narrative with claim.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per Patient. Either D7510 or D7511 on date of service.	Pre-operative radiogaphs and narrative with claim.
D7610	maxilla - open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7620	maxilla - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7630	mandible-open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7640	mandible - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7710	maxilla - open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7720	maxilla - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7730	mandible - open reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7740	mandible - closed reduction	21 and older		Yes		Pre-operative radiographs and accident narrative details with claim.
D7810	open reduction of dislocation	21 and older		Yes		Narrative of medical necessity with claim.
D7820	closed reduction dislocation	21 and older		Yes		Narrative of medical necessity with claim.
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		Pre-operative radiographs, description of service and narrative of medical necessity.

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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied.

Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act.

Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment can not be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

* Toxicity to local anesthesia supported by documentation;
* Severe mental retardation;
* Severe physical disability;
* Uncontrolled management problem;
* Extensive or complicated surgical procedures;
* Failure of local anesthesia;
* Documented medical complications; and
* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. Doral or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. The procedures will only be reimbursed for once per day regardless of the length of time it takes to complete the procedure.

General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

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IN ACCORDANCE WITH THE ILLINOIS DENTAL PRACTICE ACT AS DEFINED IN THE ILLINOIS ADMINISTRATIVE CODE 1220.500, PROCEDURE CODES D9241 AND D9248 REQUIRE A DENTAL SEDATION PERMIT A OR DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

PROCEDURE CODE D9220 REQUIRES AN DENTAL SEDATION PERMIT B IN ORDER TO PERFORM SERVICE.

Adjunctive General						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Not covered wth D0140 on same date of service.	
D9220	general anesthesia - first 30 minutes	21 and older		Yes	Not allowed on same date of service as D9230, D9241, D9242 or D9248.	Narrative of medical necessity.
D9221	general anesthesia - each additional 15 minutes	21 and older		Yes	Four per 1 Day(s) Per Patient. Not allowed on same date of service as D9230, D9241, D9242 or D9248.	Narrative of medical necessity.
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	21 and older		No	Not allowed on same date of service as D9220, D9221, D9241, D9242 or D9248.	Medical necessity must be documented in the patient's treatment record.
D9241	intravenous sedation/analgesia - first 30 minutes	21 and older		Yes	Not allowed on same date of service as D9220, D9221, D9230 or D9248.	Narrative of medical necessity.
D9242	intravenous sedation/analgesia - each additional 15 minutes	21 and older		Yes	Four per 1 Day(s) Per Patient. Not allowed on same date of service as D9220, D9221, D9230 or D9248.	Narrative of medical necessity.
D9248	non-intravenous conscious sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Not allowed on the same date of service as D9220, D9221, D9230, D9241 or D9242.	Provider must possess a Class A or Class B anesthesia permit.
D9310	consultation	21 and older		No		Narrative of medical necessity shall be maintained in patient records.
D9610	therapeutic drug injection, by report	21 and older		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9630	other drugs and/or medicaments, by report	21 and older		Yes		Narrative of medical necessity. Name of drug and amount administered.
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		Description of service and narrative of medical necessity.

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