Dental Provider Supplement to the AmeriHealth Caritas Pennsylvania Community HealthChoices Provider Manual

January 2018
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About AmeriHealth Caritas Pennsylvania Community HealthChoices

Who We Are

AmeriHealth Caritas Pennsylvania Community HealthChoices (hereinafter known as “the Plan”) is a Community HealthChoices Managed Care organization that coordinates physical health care and long-term services and supports (LTSS) for older persons with physical disabilities and Pennsylvanians who are dually eligible for Medicare and Medicaid (Community Well Duals). We are committed to delivering quality care that enables our Participants to live safe and healthy lives with as much independence as possible and to receive services in the community, preserve consumer choice, and allow them to have an active voice in the services they receive.

CHC Participants are:

Individuals 21 and older who are:

- Dually eligible for Medicare and Medicaid (Community Well Duals);
- Receiving LTSS in the Attendant Care, Independence, COMMCARE, or Aging waivers;
- Receiving care in the OBRA waiver AND determined nursing facility clinically eligible; OR
- Receiving care in a nursing home paid for by Medicaid.

Our Mission

We Help People:

Get Care
Stay Well
Build Healthy Communities

We have a special concern for those who are poor.

Our Values

Our service is built on these values:

Advocacy
Care of the Poor
Compassion
Competence
Dignity Diversity
Hospitality
Stewardship
The information contained in this Dental Provider Supplement is in addition to the information on the Plan’s Dental Program that may not be otherwise included in the Plan Provider Manual.

Single point of contact
To ensure timely, accurate Provider reimbursement and high-quality service, the Plan assigns each geographical region a dedicated Dental Account Executive. Each Dental Account Executive is responsible for building personal relationships with the office managers at each Provider location in the region. This proven approach fosters teamwork and cooperation, which results in a shared focus on improving service, Participant participation, and program results.

Support for Participants
To further reduce costs for Providers while promoting satisfaction, the Plan offers support with transportation issues and appointment scheduling for Participants. Providers may also refer Participants with health-related concerns to the Plan to address any questions they may have. This highly successful program reduces administrative costs for dentists and routinely sends satisfied, eligible Participants directly to Provider practice locations.

Consistent, transparent authorization determination logic
The Plan’s trained Dental Program team use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to Providers through a Provider Services Web site so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, the Plan fosters a sense of partnership by encouraging Providers to offer feedback about the algorithms. A consistent, well-understood approach to UM determinations promotes clarity and transparency for Providers, which in turn reduces Provider administrative costs.

Technology tools
The Plan takes advantage of technology tools to increase speed and efficiency, and keep program administration and Provider participation costs as low as possible.

Provider Services Web site – dentists.amerihealthcaritas.com
The Plan provides access to a Web site that contains the full complement of online Provider resources. The Web site features an online Provider inquiry tool for real-time eligibility, claims status and authorization status. In addition, the Web site provides helpful information such as required forms, Provider newsletter, Claim status, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines and other information to assist Providers in working with the Plan.

The Web site may be accessed at dentists.amerihealthcaritas.com. The Web site allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider Web site lowers program administration and participation costs for Providers.

All that’s required is online access to the Internet Explorer Web browser and a valid user ID and password. From Internet Explorer, Providers and authorized office staff can log in for secured access anytime from anywhere, and handle a variety of day-to-day tasks, including:

- Verify Participant eligibility
- Set up office appointment schedules, which can automatically verify eligibility and pre-populate Claim
forms for online submission

- Submit Claims for services rendered by simply entering procedure codes and applicable tooth numbers, etc.
- Submit Prior Authorization requests, using interactive clinical algorithms when appropriate
- Check the status of submitted Claims and Prior Authorization requests
- Review Provider clinical profiling data relative to peers
- Download and print Provider Manuals and dental supplement
- Send electronic attachments, such as digital x-rays, EOBs, and treatment plans
- Check patient treatment history for specific services
- Upload and download documents using a secure encryption protocol

Feedback

At the Plan, feedback from both Participants and Providers is encouraged, logged, and acted upon when appropriate. To measure Provider and Participant satisfaction, and to gather valuable feedback for its quality improvement initiatives, the Plan makes surveys available from its Web sites and through telephone calls. In addition, to help foster a sense of teamwork and cooperation, the Plan invites feedback from Providers about its UM algorithms by direct communication with the Plan’s Dental Director.
The AmeriHealth Caritas Pennsylvania Community HealthChoices Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker, submit Claims and Prior Authorization requests electronically along with the many other features listed here:

- Verify Participant eligibility and service history reports
- View PreClaim Estimate Reports
- Attach supporting documentation to claims and authorizations
- Search for and view historical claims and authorizations
- Create “provider billed amounts” lists for service codes
- Manage patient rosters and schedule appointments on the patient calendar
- Sign-up and manage payee EFT information
- Create and manage portal subaccounts for staff
- View remittances

To learn more about the features and functions of the Provider Portal, register for the portal or ask for a training webinar, please contact the Portal Support team at 855-434-9239.

Participant Eligibility Verification Procedures and Services to Participants

Participant Identification Card

Plan Participants are issued identification cards upon enrollment and when requested by the Participant.
Providers are responsible for verifying that Participants are eligible at the time services are rendered and to determine if Participants have other health insurance.

ID Card Front

ID Card Back

The Plan Eligibility Systems

Enrolled Network Providers may access Participant eligibility information through:

- The “Providers” section of the Plan’s Web site at dentists.amerihealthcaritas.com
- The Plan’s Interactive Voice Response (IVR) system eligibility line at 1-855-434-9241.
- The Plan’s Participant Services Department at 1-855-235-5115; 1-855-235-5112 TTY.

The eligibility information received from any of the above sources will be the same information. However by utilizing the IVR or the Web site, you can get information 24 hours a day, 7 days a week, without having to wait for an available Participant Service Representative.

Access to eligibility information via dentists.amerihealthcaritas.com

The Plan’s Dental Provider Web site, dentists.amerihealthcaritas.com, allows enrolled Network Providers to verify a Participant’s eligibility as well as submit Claims. To access the eligibility information or submit Claims, simply log on to the Web site at dentists.amerihealthcaritas.com.

Once you have entered the Web site, click on ‘Providers.’ You will then be able to log in using your password and ID. First time users will have to self-register by utilizing the Plan Payee ID, office name and office address. Please refer to your payment remittance or contact the Provider Web Portal team at 1-855-434-9239 for information regarding your Payee ID.

Once logged in, select “eligibility look up” and enter the applicable information for each Participant you are inquiring about. Verify the Participant’s eligibility by entering the Participant’s date of birth, the expected date of service and the Participant’s identification number or last name and first initial. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR system, simply call 1-855-434-9241 for eligibility and service history. The IVR system will be able to answer all of your eligibility questions for as many Participants as you wish to check. Once you have completed your eligibility checks or history inquiries, you will have the option to transfer to a Customer Service Representative during normal business hours.
Callers will need to enter the appropriate Tax ID or NPI number, the Participant’s recipient identification number, and date of birth. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the Participant’s eligibility for coverage of dental services will be verified. If the system is unable to verify the Participant information you entered, you will be transferred to a customer service representative.

Directions for using the Plan’s IVR system to verify eligibility:

- Call the Plan IVR system at 1-855-434-9241
- When prompted, enter your Provider NPI or Tax ID number.
- Follow the additional prompts and enter Participant Information using the ID number or SSN.
- When prompted, enter the Participant’s ID, less any alpha characters that may be part of the ID, or the SSN.
- When prompted, enter the Participant’s date of birth in MM/DD/YYYY format.
- Upon system verification of the Participant’s eligibility, you will be prompted to verify the eligibility of another Participant, inquire about service history, or choose to speak to a customer service representative.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or Web site, please contact the Participant Service Department at 1-855-235-5115. They will be able to assist you in utilizing either system.

Transportation Benefits for Certain Participants

Participants who need assistance with transportation should contact the Plan’s Participant Service Department directly at 1-855-235-5115. The Plan offers TTY service for hearing impaired Participants at 1-855-235-5112.
**Dental Benefits**

*See dental benefit grid on page 32 for procedure codes and eligibility criteria.*

Participants do not need a referral from their PCP, and can choose to receive dental care from any provider who is part of the dental network.

The following dental services are covered:

- Exams
- Cleanings - One cleaning and one dental exam, per provider/group, every 180 days
- Radiographs
- Restorations / restorative services
- Extractions
- Dentures Full and Partial *
- Dental Surgical Procedures; *
- General Anesthesia / IV or Non IV Conscious Sedation *
- Periodontal services*
- Dental prophylaxis
- Root Canals*
- Crowns*

* Prior Authorization is required and medical necessity must be demonstrated.

**Missed Appointments**

Enrolled Network Providers are not allowed to charge Participants for missed appointments. Please refer to Medical Assistance Bulletin 99-10-14 in the Appendix of the Plan Provider Manual.

The Plan offers the following suggestions to decrease the number of missed appointments.

- Contact the Participant by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

If a Participant exceeds your office policy for missed appointments and you choose to discontinue seeing the Participant, please inform them to contact the Plan for a referral to a new dentist. Providers with benefit questions should contact the Plan’s Participant Service Department directly at 1-855-235-5115.

**Payment for Non-Covered Services**

Network Providers shall hold Participants harmless for the payment of Non-Covered Services except as provided in this paragraph. Provider may bill a Participant for Non-Covered Services if the Provider obtains an agreement in writing from the Participant prior to rendering such service that indicates:

- The non-covered services to be provided;
- The Plan will not pay for or be liable for said services; and
- Participant will be financially liable for such services.

Please refer to page 32 for a complete list of covered benefits.
• Plan Authorization Requirements and Benefit Details Grid
  - For Participants 21 years of age or older; network providers may pursue an 1150 waiver/Program Exception request to determine possible coverage for services not included on the Benefit Details Grid, or to exceed limits for items that are currently on the fee schedule if the limits are not based in statute or regulation.

Electronic Attachments

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

For more information, or to sign up for Fast Attach, go to http://www.nea-fast.com or call NEA at 1-800-782-5150.
Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

The Plan has specific dental utilization criteria as well as a Prior Authorization and Retrospective Review process to manage the utilization of services. Consequently, the Plan’s operational focus is on assuring compliance with its dental utilization criteria.

Prior Authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Participant must be eligible at the time the services are provided. The Provider should verify eligibility at the time of service.

In order to timely process Prior Authorization requests, appropriate supporting documentation on a standard ADA (2012) approved form must be submitted (paper or electronic). Lack of supporting documentation may result in denial of the authorization.

AmeriHealth Caritas CHC
Prior Authorization
PO Box 654
Milwaukee, WI 53201

The basis for granting or denying approval shall be whether the item or service is Medically Necessary. Medically Necessary is defined as follows:

Medically Necessary: Compensable under the Medical Assistance Program and if it meets any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.
- Will provide the opportunity for the Participant receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Participant, the Participant's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Participant. All such determinations must be made by qualified and trained practitioners.

During the Prior Authorization process it may become necessary to have your patient clinically evaluated. If this is the case, you will be notified of a date and time for the evaluation examination. It is the responsibility of the Network Provider to ensure attendance at this appointment. Patient failure to keep an appointment will result in Denial of the Prior Authorization request.

Please refer to the Prior Authorization Requirements and Benefits Grid in this manual for a detailed list of services requiring Prior Authorization.

Prior authorization for SPU/ASC admission for dental services is not required when utilizing an AmeriHealth Caritas Pennsylvania Community HealthChoices participating facility. Please contact the Plan’s Provider Services at 1-800-521-6007 with any questions.
Retrospective Review

Services that would normally require a Prior Authorization, but are performed in an emergency situation, will be subject to a Retrospective Review. Claims for these services should be submitted to the address utilized when submitting requests for Prior Authorization, accompanied by any required supporting documentation. Any Claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.
Claim Submission Procedures

The Plan receives dental claims in four possible formats. These formats include:

- Electronic claims via the Plan’s Web site: (dentists.amerihealthcaritas.com)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

Electronic Claim Submission Utilizing the Plan’s Web site

Enrolled Network Providers may submit claims directly to the Plan by utilizing the “Provider” section of our Web site. Submitting claims via the Web site is very quick and easy and is at no additional cost to Providers!

It is especially easy if you have already accessed the site to check a Participant’s eligibility prior to providing the service. To submit Claims via the Web site, simply log on to dentists.amerihealthcaritas.com.

If you have questions on submitting Claims or accessing the Web site, please contact our Systems Operations Department at 1-855-434-9241.

Electronic Claim Submission via Clearinghouse

Dentists may submit their Claims to the Plan via a clearinghouse such as DentalXChange.

You can contact your software vendor and make certain that they have the Plan listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted Claims are forwarded to the Plan.

The Plan’s Payer ID is “SCION.” DentalXChange will ensure that by utilizing this unique payer ID, Claims will be submitted successfully to the Plan.

For more information on DentalXChange, please refer to their Web site at www.dentalxchange.com

HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, the Plan 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 Provider Services at 1-855-434-9241 to inquire about this option for electronic claim submission.

Paper Claim Submission

Claims must be submitted on 2012 ADA approved claim forms or other forms approved in advance by the Plan. Please reference the ADA Web site for the most current claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

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

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

- Participant name – box #12 or #20
- Participant DOB – box #13 or #21
- Participant ID # - box #15 or #23
- Provider name – box #53
- Tax ID # - box #51
- NPI – box #49 and box #54
- Payee location – box #48
- Treating location – box #56
- Box number specific to ADA 2012

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

Approved ADA dental codes as published in the current CDT book or as defined in this Manual must be used to define all services.

Providers must list all quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of Claim payment.

Affix the proper postage when mailing bulk documentation. AmeriHealth Caritas Pennsylvania Community HealthChoices does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

- Claims should be mailed to the following address:
  AmeriHealth Caritas Pennsylvania Community HealthChoices - Claims
  P.O. Box 651
  Milwaukee, WI 53201

- Reprocessed and adjusted claims should be mailed to the following address:
  AmeriHealth Caritas Pennsylvania Community HealthChoices
  Claims Reprocessing and Adjustments Requests
  PO Box 541
  Milwaukee, WI 53201
The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA’s web site (ADA.org).

**GENERAL INSTRUCTIONS**

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the “bookmarks” printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual’s instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

**COORDINATION OF BENEFITS (COB)**

When a claim is submitted to the secondary payer, complete the entire form and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the “Remarks” field (Item 36). There are additional detailed completion instructions in the CDT manual.

**DIAGNOSIS CODING**

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

- Item 20a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM, AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter “A”)

**PLACE OF TREATMENT**

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

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

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

**PROVIDER SPECIALTY**

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

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>122300000X</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>1223G0001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>1223D001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E0200X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X0400X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P021X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P0300X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P0700X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P0100X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D0008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S0112X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-edt.com/codes/taxonomy”
Timely Filing Limits

Provider understands that failure to submit claims or failure to submit requested documentation within 180 days from the date of service may result in loss of reimbursement for services provided.

Claims with EOBs from primary insurers must be submitted within 60 days of the date of the primary insurer’s EOB. Providers must submit a copy of the primary insurer’s EOB. The Plan determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

Coordination of Benefits (COB)

When the Plan 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, the Plan will consider the Claim paid in full and no further payment will be made on the Claim, nor may the Participant be billed for any outstanding balance.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Participant's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as the Plan, are always the payer of last resort. This means that all other insurance carriers (the “Primary Insurers”) must consider the Health Care Provider’s charges before a Claim is submitted to the Plan. Therefore, before billing the Plan when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer’s EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Participants with Third Party Resources

Medicare as a Third Party Resource

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and AmeriHealth Caritas Pennsylvania Community HealthChoices will not exceed the Plan contracted rate.

If the Participant and provider participate in both AmeriHealth Caritas VIP Care and AmeriHealth Caritas Pennsylvania Community HealthChoices, claims for dental services will be automatically sent to the secondary payer AmeriHealth Caritas Pennsylvania Community HealthChoices for claim processing.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.
The Plan’s referral and authorization requirements are applicable if the services are covered by Medicare and the Participant’s Medicare benefits have been exhausted.

**Commercial Third Party Resources**

For services that have been rendered by a Network Provider, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan’s contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health Care Providers must comply with all applicable the Plan referral and authorization requirements.

**Receipt and Audit of Claims**

In order to ensure timely, accurate remittances to each dentist, the Plan performs an edit of all Claims upon receipt. This edit validates Participant eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to the Plan dental offices 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 the Plan’s Provider Services Department at 1-800-521-6007 with any questions you may have regarding Claim submission or your remittance.

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

**Dentist Appeal Procedures**

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Plan department.

Providers may appeal a Plan reimbursement decision by submitting an appeal in writing, along with any necessary additional documentation within 60 days of the date of the explanation of benefit indicating claim denial:

AmeriHealth Caritas Pennsylvania Community HealthChoices - Appeals
P.O. Box 1243
Milwaukee, WI 53201

Refer to the Provider Manual section on "Provider Dispute/Appeal Procedures" for complete and detailed information.
As a healthcare Provider, you are a “Covered Entity” under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this Provider Manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, the Plan will require Providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA 2012 claim form.

Note: Copies of the Plan’s HIPAA policies are available upon request by contacting the Plan’s Provider Service Department at 1-800-521-6007.

For complete detailed information regarding the Plan’s HIPAA policies, refer to “Compliance with the HIPPA Privacy Regulations” in the Provider Manual.

**Fraud & Abuse**

Under the Community HealthChoices program, the Plan receives state and federal funding for payment of services provided to our Participants. In accepting Claims payment from the Plan, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIIItoc.html for more information regarding Fraud or abuse, including “Provider Prohibited Acts” that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

We are dedicated to eradicating Fraud and Abuse from our programs and cooperate in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the U.S. Department of Health and Human Services (HHS) Office of Inspector General, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services (DHS). As part of our responsibilities, the Payment Integrity department is responsible for identifying and recovering claims overpayments. The department performs several operational activities to detect and prevent fraudulent and/or abusive activities. We expect our dental partners to share this same commitment and conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.

Examples of fraudulent/abusive activities:
- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

**Reporting and Preventing Fraud, Waste and Abuse**

If you, or any entity with which you contract to provide health care services on behalf of the Plan, become concerned about or identifies potential fraud, waste or abuse, please contact us by:
- Calling the toll-free Fraud Waste and Abuse Hotline at 1-866-833-9718;
- E-mailing to FraudTip@amerihealthcaritas.com; or,
• Mailing a written statement to Special Investigations Unit, AmeriHealth Caritas Pennsylvania Community HealthChoices, 200 Stevens Drive, Philadelphia, PA, 19113.

Below are examples of information that will assist us with an investigation:
• Contact Information (e.g. name of individual making the allegation, address, telephone number);
• Name and Identification Number of the Suspected Individual;
• Source of the Complaint (including the type of item or service involved in the allegation);
• Approximate Dollars Involved (if known);
• Place of Service;
• Description of the Alleged Fraudulent or Abuse Activities;
• Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse to:
AmeriHealth Caritas Pennsylvania Community HealthChoices Fraud and Abuse Hotline by:
Phone: 1-866-833-9718
Mail: Corporate and Financial Investigations
AmeriHealth Caritas PA CHC
100 Stevens Drive
Philadelphia, PA 19113

OR

Contact The Pennsylvania Department of Human Services through one of the following methods:

Phone: 1-844-DHS-TIPS or 1-844-347-8477
On-line: www.dhs.pa.gov/learnaboutdhs/fraudandabuse/
E-mail: omaptips@state.pa.us
Fax: 1-717-772-4655, Attn: OMAP Provider Compliance Hotline
Mail: Bureau of Program Integrity
OMAP Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675
Credentialing

Any DDS or DMD who is interested in participation with the Plan is invited to apply by submitting a credentialing application form for review by the Plan Credentialing Committee.

Providers who seek participation in the Plan Provider Network must be credentialed prior to participation in the network.

The Plan maintains and adheres to all applicable State and federal laws and regulations, Pennsylvania Department of Human Services requirements, and accreditation requirements governing credentialing and recredentialing functions. All applications reviewed by the Plan must satisfy these requirements, as they apply to dental services, in order to be admitted the Plan Provider Network.

The process to be credentialed as a Plan Network Provider is fast and easy. The Plan has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our Providers the Universal Provider Datasource that simplifies and streamlines the data collection process for credentialing and recredentialing. Through CAQH, you provide credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. The Plan’s goal is to have all of its Network Providers enrolled with CAQH. There is no charge to Providers to submit applications and participate in CAQH. Please access the credentialing page on dentists.amerihealthcaritas.com and follow the instructions to begin the application process for participation in the Plan’s Provider Network.

Refer to the Plan Provider Manual section on Credentialing and Recredentialing Requirements for complete and detailed information.
Medical Recordkeeping

The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Likewise, the Plan expects that every office will provide quality dental services in a cost effective manner in keeping with the standards of care in the community and dental profession nationwide.

The Plan’s expectation is that every Network Provider will submit claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that Network Providers are compliant with these requirements.

The Plan will periodically conduct random chart audits in order to determine Network Providers’ compliance with these conditions and expectation, as a component of the Plan’s Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Participant dental records. The records are reviewed by the Plan’s Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 80% are considered as passing the audit but a corrective action letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 80% will have a corrective action letter sent, and are re-reviewed for compliance within the next ninety days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with the Plan’s Provider Sanctioning Policy.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes are compared to the actual Claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Any services not documented are recouped, and the records may be subject to additional review and follow-up by the Plan’s Special Investigations Unit.

Results of both parts of the audit are entered into a tracking data base at the Plan and then reported back to each office in a summary of finding format.

The Plan 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 from the date of the last dental entry.

Refer to the Quality Management, Credentialing and Utilization Management Section of the Provider Manual for more information.
Important Notice for Submitting Paper Authorizations and Claims

Only the ADA 2012 form will be acceptable for submission of paper claims and authorizations.

Additionally, when making a correction to a previously submitted Claim, please send it clearly marked “Corrected Claims” on ADA 2012 forms to the Claims Reprocessing and Adjustment Request mailbox
P.O. Box 541
Milwaukee, WI  53201

Please contact Provider Services at 1-855-434-9241 if you have questions. If you are in need of the current forms, please visit the ADA Web site at www.ada.org for ordering information.

Claims /Authorizations with missing or invalid information may be rejected and returned to the Provider.

Prior Authorization requests must include the following:

- Participant name – box #12 or #20
- Participant DOB – box #13 or #21
- Participant ID # - box #15 or #23
- Provider name – box # 53
- Tax ID # - box #51
- NPI – box #49 and box #54
- Payee location – box #48
- Treating location – box #56
- Box number specific to ADA 2012

Authorizations with missing or invalid information may be rejected and returned to the Provider.

All radiographs including digital prints, duplicates, and originals will not be returned to the dentist unless a self-addressed stamped envelope is included with the claim/authorization submission.

Authorizations should be mailed to the following address:

AmeriHealth Caritas Pennsylvania Community HealthChoices– Authorizations
P.O. Box 654
Milwaukee, WI 53201
Clinical Criteria for Prior Authorization of Treatment and Emergency Treatment

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to AmeriHealth Caritas Pennsylvania Community HealthChoices. The criteria the Plan Dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient’s condition. However, to receive reimbursement for the treatment, the Plan will require the same criteria / documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

The Dental Benefit Limit process does not apply to Community HealthChoices Participants.

The Plan will accept requests for Community HealthChoices Participants through the Program Exception Process (1150 Administrative Waiver Process) to exceed limits for items that are currently on the fee schedule if the limits are not based in statute or regulation and for items or services which are included in the participants benefit package but are not currently listed on the Medical Assistance (MA) program fee schedule.

**Crowns (D2710, D2721, D2740, D2751, D2752, D2791) – prior authorization**

For CHC participants, crown coverage is limited to one crown per tooth for five years and is limited to four per calendar year with no more than two crowns per arch. Procedure code D2710; crown-resin (indirect) is limited to one crown per three years. The fees for crowns include buildup of the natural crown using either composite or amalgam.

Required documentation – Periapical x-ray showing the root and crown of the natural tooth. Current periapical x-rays of the tooth/teeth to be crowned and/or used as abutments for removable partial dentures along with a panorex or full mouth are needed for evaluation

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  - The tooth is filled within two millimeters of the radiographic apex
  - The root canal is not filled beyond the radiographic apex
  - The root canal filling is adequately condensed and/or filled
- And 1 of the criteria below must be met:
  1. Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
  2. Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
  3. Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps
**Posts and cores (D2952, D2954) – prior authorization**

Required documentation – Periapical x-ray showing the root and crown of the natural tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex
  2. The root canal is not filled beyond the radiographic apex
  3. The root canal filling is adequately condensed and/or filled

**Root canals (D3310, D3320, D3330) – prior authorization**

Required documentation – pre-operative x-rays (excluding bitewings)

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- Closed apex
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
  1. Evidence of apical pathology/fistula
  2. Pain from percussion / temp

**Apicoectomy / periradicular services (D3410, D3421, D3425, D3426) – prior authorization**

Required documentation – pre-operative x-rays of adjacent and opposing teeth

All criteria below must be met:

- Minimum 50% bone support
- History of RCT
- Apical pathology
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or furcation involvement

**Gingivectomy or gingivoplasty (D4210) – prior authorization**

Limited to no more than four different quadrant reimbursements within a 24 month period.

Required documentation – pre-operative x-rays, perio charting, narrative of medical necessity, photo (optional)

1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the perio charting
**Periodontal scaling and root planning (D4341) – prior authorization**

Limited to no more than four different quadrant reimbursements within a 24-month period

Required documentation – periodontal charting and pre-operative x-rays

All criteria below must be met:
- Four or more teeth in the quadrant
- 5 mm or more pocketing on 2 or more teeth indicated on the perio charting
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

**Full mouth debridement (D4355) – prior authorization**

Limited to one treatment per 365 days.

Required documentation – pre-operative x-rays

All criteria below must be met:
- No history of periodontal treatment in past 12 months
- Extensive coronal calculus on 50% of teeth

**Periodontal maintenance (D4910) – prior authorization**

Up to four procedures of any combination of routine prophylaxis and periodontal maintenance totaling four may be paid within a 12 consecutive month period.

Required documentation – Date of previous periodontal surgical or scaling and root planning

All criteria below must be met:
- Periodontal surgical or scaling and root planning service at least 90 days prior

**Full dentures (D5110, D5120) – prior authorization**

Complete dentures are limited to one per arch, regardless of procedure code (D5110, D5120, D5130, D5140), every five years.

Required documentation – Full mouth or panorex x-rays

1 of the criteria below must be met:
- Existing denture greater than 5 years old
- Remaining teeth do not have adequate bone support or are not restorable

**Immediate dentures (D5130, D5140) – prior authorization**

Complete dentures are limited to one per arch, regardless of procedure code (D5110, D5120, D5130, D5140), every five years.

Required documentation – Full mouth or panorex x-rays

All criteria below must be met:
- Remaining teeth do not have adequate bone support or are not restorable
**Partial dentures (D5211, D5212, D5213, D5214) – prior authorization**

Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars) on the denture all of which must be anatomically correct (natural size, shape and color) to be compensable; limited to one per arch, regardless of procedure code, every five years.

Required documentation – Full mouth or panorex x-rays.

All criteria below must be met:
- Remaining teeth have greater than 50% bone support and are restorable

In addition 1 of the criteria below must be met
- Replacing one or more anterior teeth
- Replacing two or more posterior teeth unilaterally (excluding 3rd molars)
- Replacing three or more teeth bilaterally (excluding 3rd molars)
- Existing partial denture greater than 5 years old

**Impacted teeth – (asymptomatic and disease free impactions will not be approved) (D7220, D7230, D7240) – prior authorization**

Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity
- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- X-rays matches type of impaction code described
- Documentation of clinical evidence indicating impaction although asymptomatic may not be disease free

**Surgical removal of residual tooth roots (D7250) – prior authorization**

Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity

All criteria below must be met:
- Tooth root is completely covered by tissue on x-ray
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic)

**Oroantral fistula closure (D7260) – retrospective review**

Documentation required – Narrative of medical necessity

All criteria below must be met:
- Narrative must substantiate need due to extraction, oral infection or sinus infection

**Tooth reimplantation and / or stabilization (D7270) – retrospective review**

Documentation required – Narrative of medical necessity

All criteria below must be met:
- Documentation describes an accident such as playground fall or bicycle injury
- Documentation describes which teeth were avulsed or loosened and treatment necessary to stabilize them through reimplantation and/or stabilization

**Alveoloplasty with extractions (D7310) – prior authorization**
Documentation required – Pre-operative x-rays (excluding bitewings).
All criteria below must be met:
• Appropriate number of teeth being extracted (three or more)

**Alveoloplasty without extractions (D7320) – prior authorization**
Documentation required – Pre-operative x-rays (excluding bitewings) and narrative of medical necessity
All criteria below must be met:
• Documentation supports medical necessity for fabrication of a prosthesis

**Excision of lesion / tumor (D7450, D7451, D7460, D7461) – retrospective review**
Documentation required – Copy of pathology report
All criteria below must be met:
• Copy of pathology report indicating lesion / tumor

**Incision / drain abscess (D7510, D7511, 7520, 7521) – retrospective review**
Documentation required – Narrative of medical necessity, x-rays or photos optional
All criteria below must be met:
For intraoral incision:
• Documentation describes non-vital tooth or foreign body

For extraoral incision
• Documentation describes periapical or periodontal abscess

**Reduction and dislocation and management of TMJ dysfunctions (D7871) – retrospective review**
Documentation required – Narrative of medical necessity, x-rays or photos optional
All criteria below must be met:
• Documentation describes nature and etiology of TMJ dysfunction
• Documentation describes treatment to manage the TMJ condition

**Frenulectomy (D7960) – prior authorization**
Documentation required – Narrative of medical necessity, x-rays or photos optional
All criteria below must be met:
• Documentation describes tongue tied, diastema or tissue pull condition

**Excision of hyperplastic tissue (D7970) – prior authorization**
Documentation required – Pre-operative x-rays, narrative of medical necessity, photos optional
All criteria below must be met:
• Documentation describes medical necessity due to ill-fitting denture

**Unspecified oral surgery procedure (D7999) – prior authorization**

Documentation required – Narrative of medical necessity, name, license number and tax ID of Asst surgeon

All criteria below must be met:

- Documentation describes medical necessity need for Asst surgeon
- Name / license number of Assistant surgeon is provided

**General anesthesia / IV sedation (Dental Office Setting) - 1 or more of the criteria below (D9222, D9223, D9239 and D9243) – retrospective review**

- Documentation required – Narrative of medical necessity

  1 of the criteria below must be met:

  - Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
  - 2 or more extractions in 2 or more quadrants
  - 4 or more extractions in 1 quadrant
  - Excision of lesions greater than 1.25 cm
  - Surgical recovery from the maxillary antrum
  - Documentation of failed local anesthesia
  - Documentation of situational anxiety
  - Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)
  - Documentation of existing clinical condition or circumstance making the use of the general anesthesia/IV sedation a reasonable inclusion as a medically necessary part of the therapeutic regimen.

**Non-intravenous conscious sedation (Dental Office Setting) - 1 or more of the criteria below (D9248) – retrospective review**

Documentation required – Narrative of medical necessity

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)
- Documentation of existing clinical condition or circumstance making the use or the non-intravenous conscious sedation a reasonable inclusion as a medically necessary part of the therapeutic regimen.
Treatment of complications (post-surgical) – (D9930) – retrospective review

Documentation required – Narrative of medical necessity
  • Documentation describes post-surgical condition supporting medical necessity for procedure

Orthodontics

Comprehensive orthodontic services (D8670) – prior authorization

Documentation requirements – Previous approval notification from a Community HealthChoices managed care organization.

Payment records and ADA 2012 request.

Criteria below must be met:
  • If Participant was banded before the age of 21, the Plan will continue to cover orthodontic services until orthodontic services are complete or age 23 whichever comes first, as long as the Participant remains eligible in the AmeriHealth Caritas Pennsylvania Community HealthChoices plan.
## Dental Benefit Grid

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
<th>Authorization Requirements</th>
<th>Benefit Details</th>
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<tr>
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<td>D1555</td>
<td>Removal of fixed space</td>
<td>No</td>
<td>N/A</td>
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<td>D2140</td>
<td>Amalgam - one surface,</td>
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<td>D2150</td>
<td>Amalgam - two</td>
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<td>Amalgam - four</td>
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<td>D2331</td>
<td>Resin-2 surface, anterior</td>
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<td>D2332</td>
<td>Resin-3 surface, anterior</td>
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<td>D2335</td>
<td>Resin-4+ surfaces or anterior</td>
<td>No</td>
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<td>D2391</td>
<td>Composite - 1 surf, posterior</td>
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<td>D2392</td>
<td>Composite - 2 surf, posterior</td>
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<td>Composite - 3 surf, posterior</td>
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<td>Resin-4+ surf, posterior</td>
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<td>Crown - resin (laboratory)</td>
<td>Yes</td>
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<td>Crown-resin with base metal</td>
<td>Yes</td>
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<td>Crown-porcen/ceramic</td>
<td>Yes</td>
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<td>Crown-porcen fused to metal</td>
<td>Yes</td>
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<td>D2752</td>
<td>Crown-porcen fused noble metal</td>
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<td>Crown - full cast base metal</td>
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<td>Recement inlay</td>
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<td>D2915</td>
<td>Recement cast or prefabricated post and core</td>
<td>Yes</td>
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<td>D2920</td>
<td>Recement crown</td>
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<td>Cast post and core, in addition to crown</td>
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<td>D2954</td>
<td>Prefab post/core</td>
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<td>Crown repair, by report</td>
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<td>Endodontic therapy, anterior (exc final rest)</td>
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<td>Endodontic therapy, premolar (exc final rest)</td>
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<td>Endodontic therapy, molar (exc final rest)</td>
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<td>Apicoectomy/periradicular</td>
<td>Yes</td>
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<td>Gingivectomy-gingivoplast/quad</td>
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<td>Perio scaling &amp; root plan/quad</td>
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<td>Full mouth debridement</td>
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<td>Mandibular part denture-resin</td>
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<td>Maxillary part denture-cst mtl</td>
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<td>Mandibular part denture-cast metal</td>
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<td>D5410</td>
<td>Adjust comp dent -</td>
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<td>Adjust comp dent-</td>
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<td>Adj partial dent-</td>
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<td>Adj partial dent-</td>
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<td>Repair complete broken base - mandibular</td>
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<td>Replace broken teeth-</td>
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<td>Add tooth to partial</td>
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<td>D5660</td>
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<td>Reline comp max dent chairside</td>
<td>No</td>
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<td>D5750</td>
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<td>D5751</td>
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<td>D5761</td>
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<td>D6930</td>
<td>Recement fixed partial</td>
<td>No</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D6980</td>
<td>Fixed partial denture - repairs</td>
<td>No</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>No</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7210</td>
<td>Surgical removal</td>
<td>No</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7220</td>
<td>Removal impacted tooth-soft</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7230</td>
<td>Remove impact tooth- part bony</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7240</td>
<td>Remove impact tooth – comp bony</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7250</td>
<td>Surg remove residual roots</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7260</td>
<td>Oroantral fistula closure</td>
<td>Yes</td>
<td>Narrative of medical necessity</td>
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<td>D7270</td>
<td>Tooth reimplantation - accident</td>
<td>Yes</td>
<td>Narrative of medical necessity</td>
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<td>D7288</td>
<td>Brush biopsy -</td>
<td>No</td>
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<td>D7310</td>
<td>Alveoloplasty w extract/quad</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings)</td>
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<td>Alveoloplasty - per quad</td>
<td>Yes</td>
<td>Pre-operative x-rays (excluding bitewings) and narrative of medical necessity</td>
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<td>D7450</td>
<td>Rem cyst/tumor-lesion &lt;=1.25cm</td>
<td>Yes</td>
<td>Copy of pathology report; tooth letter/number</td>
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<td>D7451</td>
<td>Rem cyst/tumor-lesion &gt;1.25cm</td>
<td>Yes</td>
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<td>D7460</td>
<td>Rem cyst/tumor-lesion &lt;=1.25cm</td>
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<td>D7461</td>
<td>Rem cyst/tumor-lesion &gt;1.25cm</td>
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<td>D7471</td>
<td>Removal of exostosis -</td>
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<td>Removal of torus</td>
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<td>Removal of torus</td>
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<td>D7485</td>
<td>Surg reduc of osseous</td>
<td>No</td>
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<td>Incision/drain abscessintraor</td>
<td>Yes</td>
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<td>Incision and drainage - intraoral - complicated</td>
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<td>Incision/drain abscessextraor</td>
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<td>D7521</td>
<td>Incision and drainage - extraoral - complicated</td>
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<td>D7871</td>
<td>Non-arthroscopic lysis and lavage</td>
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<td>D7960</td>
<td>Frenulectomy-separate proc</td>
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<td>Excise hyperplastic tiss/arch</td>
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<td>Unspecified oral surgery proc</td>
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<td>D9110</td>
<td>Palliative (emergency)</td>
<td>No</td>
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<td>D9222</td>
<td>Deep sedation/general anesthesia – first 15 minutes</td>
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<td>D9223</td>
<td>Deep sedation/general anesthesia – each subsequent 15 minute increment</td>
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<td>Intravenous moderate (conscious) sedation/analgesia – first 15 minutes</td>
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<td>Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment</td>
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<td>D9248</td>
<td>Non-intravenous conscious sedation</td>
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<td>Behavior management,</td>
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<td>Treat complication (postsurg)</td>
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<td>Mileage for home, skilled nursing, facility and ICF visits</td>
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<td>21079</td>
<td>Interim Obturator Prosthesis</td>
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<td>21080</td>
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<td>21081</td>
<td>Mandibular Resection Prosthesis</td>
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<td>21082</td>
<td>Palatial Augmentation Prosthesis</td>
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<td>Palatial Lift Prosthesis</td>
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<td>Speech Aid Prosthesis</td>
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<td>Facial Prosthesis</td>
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<td>D0160</td>
<td>Detailed and Extensive Oral Evaluation</td>
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<td>D0170</td>
<td>Re-evaluation, Limited Problem Focused</td>
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