

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections
MEDICAID



DENTAL SERVICES PROVIDER MANUAL

JULY 1, 2019

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

The dental benefit component of **Healthy Connections** is administered on an Administrative Services Organization (ASO) basis. The State of South Carolina (South Carolina or State) Department of Health and Human Services (SCDHHS) Dental ASO Vendor is DentaQuest, LLC (DentaQuest). DentaQuest processes claims based on SCDHHS' fee schedule and coverage policies, and SCDHHS, acting as its own fiscal agent, retains responsibility for claim payments to Providers.

The Dental Services Provider Manual supplements SCDHHS's general policies and procedures detailed in the Provider Administrative and Billing Manual, while provides policies and requirements specific for dental services and dental providers.

Providers must review, reference and comply with both Dental Services Manual and the Provider Administrative and Billing Manual.

This manual is the property of SCDHHS and any portion of this manual copied without permission of SCDHHS is prohibited. SCDHHS makes every effort to assure that the information in this manual is accurate. Please contact us should you discover an error.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Change Control Record](#)

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Medicaid Beneficiaries Eligible for Dental Benefits

Only beneficiaries eligible for full Medicaid benefits, which fall into the following subgroups, may receive medically necessary dental services:

Children

This group includes beneficiaries age 0 through 20 years (through the last day of the month of their 21st birthday).

Intellectually Disabled and Related Disabilities (ID/RD) Waiver Members

The ID/RD Waiver program is administered by the South Carolina Department of Disabilities and Special Needs (SCDDSN). Beneficiaries applying for enrollment in the ID/RD Waiver program must meet specific guidelines based on their medical condition to be enrolled in the program. The ID/RD Waiver program has limited capacity and is not inclusive of all Beneficiaries with special healthcare needs.

Adults

This group includes beneficiaries ages 21 years and older.

Medicaid Beneficiaries Ineligible for Dental Benefits

Beneficiaries enrolled in Family Planning and Qualifying Individuals, Specified Low Income Medicare Beneficiaries (SLMB) or as Qualified Medicare Beneficiaries (QMB) are NOT eligible for dental benefits.

Verifying Beneficiary's Eligibility

Participating **Healthy Connections** Providers must access Beneficiary eligibility information through the SCDHHS' Dental Vendor (DentaQuest) Web Portal or Customer Service Center. Providers must have login access with DentaQuest in order to use any of these systems.

First time users will have to register with DentaQuest by utilizing the Business's National Provider Identifier (NPI) or Tax ID Number (TIN), state and zip Code. Please contact DentaQuest's South Carolina Customer Service Center at +1 888 307 6553 for assistance.

DentaQuest Web Portal

DentaQuest's web portal currently allows Providers to verify a Beneficiary's eligibility, service history, annual balance (if applicable) as well as submit claims directly to DentaQuest.

- Go to www.dentaquest.com
- Click on the "Dentist" icon.
- Choose "South Carolina" and press "go".
- Log in using the password and ID (set up in advance with DentaQuest).
- Once logged in, select "Patient" and then "Beneficiary Eligibility Search".
- Enter the Beneficiary's date of birth, the expected date of service and the Beneficiary's Medicaid identification number or the Beneficiary's full last name and first initial.

The Web Portal provides ability to check an unlimited number of Beneficiaries and print off the summary of eligibility given by the system for record purposes.

DentaQuest Customer Service Center

DentaQuest Customer Service Center allows providers to verify a Beneficiary's eligibility, service history or benefit information and can be reached at +1 888 307 6553:

- By speaking directly with a Customer Service Representative during working hours Monday–Friday from 8:00 am to 6:00 pm EST, or
- By utilizing the *Interactive Voice Response (IVR)* system accessible 24 hours per day, 7 days per week.

Note: Providers will need to have their NPI numbers and the last four digits of their TIN ready. A Participating Provider's TIN, on record as a part of Provider Enrollment, is most likely the federal Employment Identification Number (EIN), but in select cases may be a Social Security Number (SSN).

Documenting Beneficiary Eligibility

Beneficiaries must be eligible on the date of service for payment to be made. However, please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If a Participating Provider has documentation that a Beneficiary was verified as eligible for the date of service and yet the claim is denied due to a possible change in eligibility status after the date of service, the Provider will be paid for the services rendered. It is very important that Providers document the date and time that the Beneficiary eligibility was verified via IVR or by the Web Portal

by printing a copy of the verification and keeping it in the beneficiaries' record. This will serve as proof that eligibility was verified.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Center at +1 888 307 6553. They will be able to assist you in utilizing either system.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

An eligible provider is an individual dental professional or a group of dental professionals practicing as one business entity that has a written participation agreement in effect with SCDHHS to provide dental services to Beneficiaries of the **Healthy Connections** program.

As it relates to delivery of dental services, a Medicaid enrolled provider will be referred to as “dental provider”.

According to 42 CFR 440.100 dental services are defined as:

- “Dental services” means diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of:
 - The teeth and associated structures of the oral cavity, and
 - Disease, injury or impairment that may affect the oral or general health of the beneficiary.
- “Dentist” means an individual licensed to practice dentistry or dental surgery.

Dental Provider Medicaid Enrollment and Participation Requirements

A dental provider must meet all the SCDHHS Provider Enrollment requirements listed in the Provider Administrative and Billing Manual.

Additionally, a dental provider must meet the following requirements:

- Be licensed and physically located in South Carolina or within a 25-mile radius of the State border.
 - Dental Providers located within 25 miles of the South Carolina border, will be considered in-State dental providers. They must enroll as a participating provider with SCDHHS to be eligible for reimbursement for services provided to eligible South Carolina Medicaid beneficiaries.
 - Dental Providers located outside of 25 miles of the South Carolina border will be considered Out-of-State dental providers. They must enroll as a participating provider with SCDHHS. Enrolled Out-of-State providers may be reimbursed only for emergency dental services provided to the eligible South Carolina Medicaid beneficiaries.

- Licensure by the appropriate licensing body, certification by the standard-setting agency and/or other pre-contractual approval processes established by SCDHHS.
- All rendering providers must be enrolled in the Medicaid program.
- Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled dentist.

Participating Dental Providers are expected to meet minimum standards with regards to appointment availability. These standards are:

- Emergency Care — As quickly as the situation warrants.
- Urgent Care — Within 48 hours.
- Routine Care — Not to exceed 6 weeks.

VALUE-ADDED PROVIDER BENEFITS

Dedicated Call Center for Providers

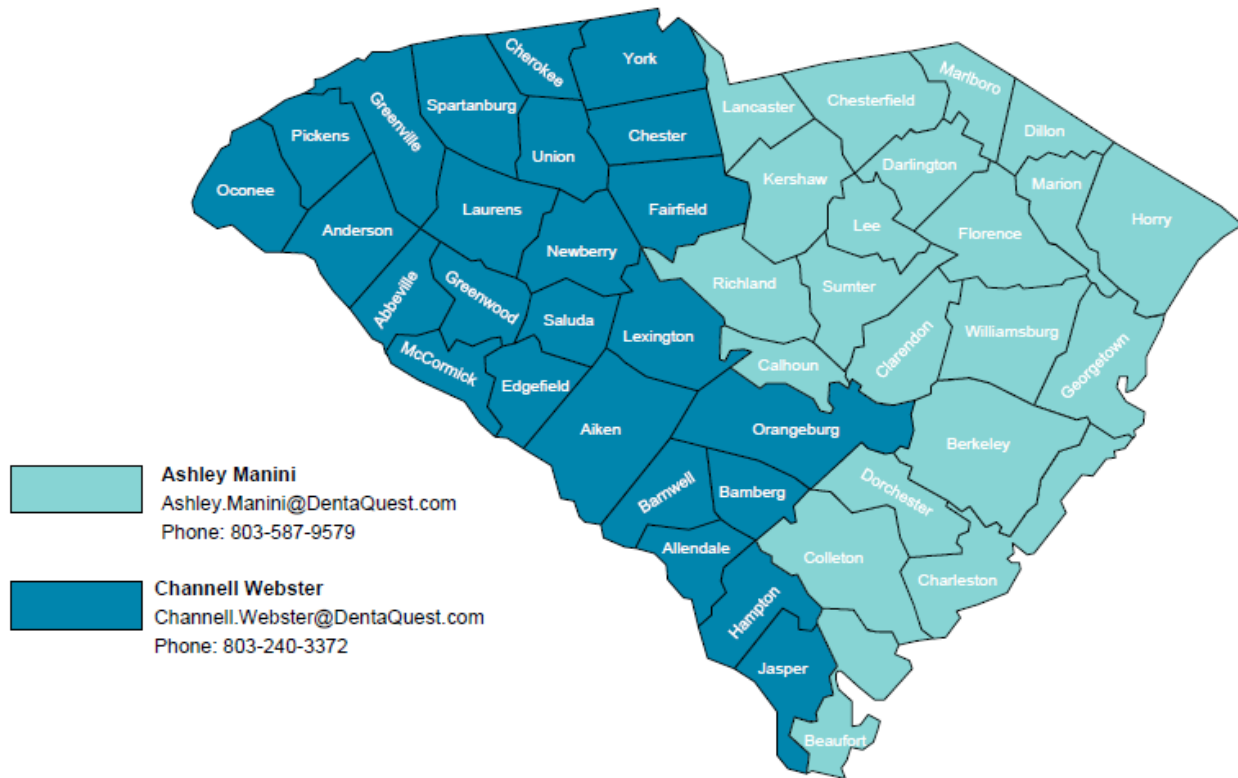
DentaQuest offers Participating Providers access to call center representatives who specialize in areas such as:

- Eligibility, benefits and authorizations,
- Beneficiary access to care/Provider connections, and
- Claims.

You can reach these representatives by calling +1 888 307 6553 from 8:00 am–6:00 pm Monday–Friday, except on stated holidays.

Provider Training

DentaQuest offers free Provider training sessions periodically throughout the State of South Carolina. These sessions include important information such as: claims submission procedures, pre-payment and prior authorization (PA) criteria, how to access DentaQuest’s clinical personnel, etc. In addition, Providers can contact the South Carolina Provider Partners and Outreach Coordinator for assistance. Providers may also request a personal, in-office visit, by contacting their Provider Partners, Ashley Manini or Channel Webster. county assignment for each Provider Partner is shown on the map below:



Provider Newsletters

DentaQuest publishes periodic Participating Provider newsletters that include helpful information of interest to Providers. To view a copy of the DentaQuest Provider newsletter online, go to <http://www.dentaquest.com>, Click on “About Us”, next select “Newsletters” where a PDF version of the newsletter can be downloaded and saved or printed.

Information specifically for **Healthy Connections** Dental Providers can be found through the DentaQuest website. Important announcements are placed on the homepage and resources can be found through the “Related Documents” link.

DentaQuest Website

DentaQuest’s website includes a “For Providers Only” web portal that allows Participating Providers access to several helpful options including:

- Beneficiary Eligibility Verification
- Claims Submission and Claim Status View
- Authorization Submission and Status View
- Create Claim Tracking Reports
- Beneficiary Service History

- Annual Maximum Accumulator for Adult Beneficiaries
- Remittance Advices
- Event and Training Calendar
- Links to Resources, Tips and Forms such as:
 - SCDHHS Dental Fee Schedule
 - Dental Services Provider Manual
 - Provider Bulletins and Alerts
 - Appointment Assistance and Dental Recall System Tips
 - Broken/Cancelled Appointment Log Instructions
 - SCDHHS Form 205 (Provider Refund Form)
 - SCDHHS Form 130 (Void/Adjustment Form)
 - Claim Reconsideration Form
 - 837D and 837P Companion Manuals
 - ANSI Manual for Dental Healthcare Transactions
 - TPL Form (DHHS 931)
 - Oral Health Education Resources

For more information regarding DentaQuest's website, contact DentaQuest's South Carolina Customer Service Center at +1 888 307 6553.

Other Value-Added Provider Benefits

Other value-added Provider benefits (detailed in other sections of this manual) include:

- Dedicated South Carolina Project Director, Local Provider Partners and Local Dental Consultants
- Defined PA Requirements for Place of Service (POS)
- Peer Review Process
- Satisfaction Surveys (Provider and Beneficiary)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. A component of our compliance plan is working cooperatively with Providers to comply with the HIPAA regulations, including the following:

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

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

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service Center at +1 888 307 6553 or via email at denelig.benefits@dentaquest.com.

Please find a link to the online American National Standards Institute (ANSI) Companion Manual for Dental Healthcare Transactions under the "Related Documents" on the DentaQuest Web Portal.

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COVERED SERVICES AND DEFINITIONS

DEFINITIONS

1. “*Dental Services*” are defined as any covered diagnostic, preventive, therapeutic, rehabilitative or corrective procedure.
2. “*Covered Services*” means a dental or medical health service, including those services covered through the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program that satisfies all of the following criteria:
 - A. Is medically necessary.
 - B. Is provided to an enrolled Beneficiary by a Participating Provider.
 - C. Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.
 - D. Is not rendered for cosmetic or experimental purposes.
3. “*DentaQuest*” shall refer to DentaQuest, LLC
4. “*Emergency Medical Services*” means covered services, as it relates to Beneficiaries, that are needed to evaluate or stabilize an emergency medical condition and are furnished by a provider that is qualified to furnish these services, in this case those qualified providers are oral surgeons.
5. “*Emergency*” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention will place the health of the individual in serious jeopardy or will cause serious impairment of bodily functions, or will cause serious dysfunction of any bodily organ or part.
6. “*EPSDT*” means the Early and Periodic Screening, Diagnosis, and Treatment program for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)43, 1396d(a) and I and 42 C.F.R. Part 441, Subpart B to ascertain children’s individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.
7. “***Healthy Connections***” is the name of the program provided to South Carolina Medicaid Beneficiaries under the direction of SCDHHS.

8. “*Medically Necessary*” means covered medical, dental, behavioral, rehabilitative or other health care services which:
- A. Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability,
 - B. Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a Beneficiary’s medical conditions,
 - C. Are consistent with the diagnoses of the conditions,
 - D. Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence, and
 - E. Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Medical necessity or any referral information must be documented in the Beneficiary’s medical record and must include a detailed description of services rendered.

9. “*SCDDSN*” means the South Carolina Department of Disabilities and Special Needs, which handles enrollment for the ID/RD Waiver program.

COVERED SERVICES

Beneficiaries eligible for full benefits are eligible for dental services. Covered dental services are defined as follows:

South Carolina State Plan for Medical Assistance (State Plan) Covered Services

Children, ID/RD Waiver and Adult Beneficiaries are eligible for State Plan covered services which include:

- **Preventive Dental Benefit:**
 - Medically necessary specified diagnostic, preventive, restorative, endodontic, prosthodontic removable, dental extractions and adjunctive services with limitations through established policies.
 - As of December 1, 2014, eligible Medicaid Beneficiaries age 21 and over have \$750 available annually towards State Plan covered services Preventive Dental Benefit. The \$750 benefit is an annual maximum that is available for a 12-month period that will match the State Fiscal Year (July 1 through June 30 of the following year). Dental Sedation Services within the Preventive Dental Benefit do not count towards the \$750 annual limit.

- **Emergency or Repair of Traumatic Injury (Oral and Maxillofacial diagnostic and Surgical Services):**
 - Medically necessary specified dental and medical diagnostic and surgical services for emergency and/or repair of traumatic injury; Medical services must be performed by Oral Surgeons only.

- **Exceptional Medical Conditions:**
 - Medically necessary dental and medical services delivered in preparation for, or during the course of treatment for:
 - › Organ transplants.
 - › Radiation of the head or neck for cancer treatment.
 - › Chemotherapy for cancer treatment.
 - › Total joint replacement.
 - › Heart valve replacement.
 - Medical services must be performed by Oral Surgeons only.

Note: Managed Care Organization (MCO) plans may elect to cover adult dental procedures that are not a part of the Healthy Connections fee-for-service dental program benefits. Reimbursement for these non-covered procedures requires Provider enrollment in the MCO network and is paid directly by the MCO.

Non-State Plan Covered Services — EPSDT Services*

Children ages zero through 20 years through the last day of the month of the 21st birthday are eligible for EPSDT services.

EPSDT benefit is detailed on the SCDHHS EPSDT website at: <https://msp.scdhhs.gov/epsdt/site-page/dental-services>.

Note: *EPSDT Services: Federal law at 42 U.S.C. § 1396d(r) [§1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the State Plan. EPSDT dental services include those provided at intervals that meet reasonable standards of dental practice and at intervals necessary to determine the existence of a suspected illness or condition.*

SCDHHS has developed a Dental Periodicity Schedule that follows the American Academy of Pediatric Dentistry recommendations on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents accessible at: <https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule>.

A summary of the dental benefits is shown below:

Benefits Summary

Benefit Name	Benefit Description	Benefit Coverage		
		Child age 0-20	ID/RD Waiver Age 21+	Adult age 21+
Preventive Dental Benefit	Medically necessary specified diagnostic, preventive, restorative, endodontic, prosthodontic removable, dental extractions and adjunctive services with limitations through established policies.	Yes	Yes	Yes
Emergency or Repair of Traumatic Injury	Medically necessary dental and medical services for emergency and/or repair of traumatic injury; Medical services performed by Oral Surgeons only.	Yes	Yes	Yes (Annual limit does not apply)
Exceptional Medical Conditions	Medically necessary dental and medical services delivered in preparation for, or during the course of treatment for: <ul style="list-style-type: none"> • Organ transplants, • Radiation of the head or neck for cancer treatment, • Chemotherapy for cancer treatment, • Total joint replacement, • Heart valve replacement. Medical services performed by Oral Surgeons only.	Yes	Yes	Yes (Annual limit does not apply)
EPSDT Services	Any medically necessary dental service not otherwise listed as a State Plan covered service or when delivered outside of the SCDHHS established policies.	Yes	No	No
Co-Pay of \$3.40	Non-emergency services.	No ¹ (Ages 19–20)	No ²	Yes ³
Annual Limit (July 1–June 30)		No Limit	No Limit	\$750 ⁴

¹ Beneficiaries ages 0–18 (up to the month of the 19th birthday) are exempt from co-payments.

² Beneficiaries in the ID/RD Waiver are exempt from co-payments.

³ Beneficiaries age 21 years and older that are: pregnant, nursing homes resident, receive hospice care, are federally recognized Native Americans, end stage renal disease recipients, receiving emergency services are exempt from co-payment.

⁴ Dental Adjunctive services, Oral and Maxillofacial Emergency services and services for Exceptional Medical Conditions are not included in the Adult Benefit annual limit of \$750.

CHARGE LIMITS

The current SCDHHS fee schedule for covered dental services can be found at: <https://www.scdhhs.gov/resource/fee-schedules>. Payment for approved EPSDT services must be accepted as payment in full.

The reimbursement fee for a dental procedure is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include, but are not limited to: materials, supplies, trays, surgical trays, equipment, topical or local anesthesia and post-operative care. None of these items or related activities/services are separately billable to SCDHHS, the Beneficiary or to the Beneficiary's representative.

Providers may not charge SCDHHS more for services to a Beneficiary than customarily charged to the general public. Providers should bill their usual charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the established Medicaid reimbursement rate, determined by the program or the Provider's charges, whichever is lower. Once a provider has accepted a Beneficiary as a Medicaid patient, the Provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the Beneficiary, Beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the Provider's actual charge, or for any coinsurance or deductible not paid by a third party. *In addition, Providers may not charge the patient for the primary insurance carrier's co-payment.*

The **Healthy Connections** Medicaid program will not pay for services or items that are furnished gratuitously without regard to the Beneficiary's ability to pay, or where no payment from any other source is expected.

Billing covered procedures prior to the date of service is prohibited.

Billing Beneficiaries for claims denied due to "untimely filing" is prohibited.

Providers must not bill the Beneficiary for any services the Beneficiary is eligible to receive under the **Healthy Connections** Medicaid program, with the exception of co-payments when applicable. Medicaid payments may be made only to a Provider, a Provider's employer or an authorized billing entity. Payments will not be reimbursed to a Beneficiary. Therefore, seeking payment from a Beneficiary is prohibited except where a co-payment is applicable. For services and beneficiaries that are exempt from co-pay, refer to the Provider Administrative and Billing Manual. To be certain that the co-payment exclusion for the provision of emergency services is applied, Providers should indicate "EMERGENCY" in the "Notes" field of the Americans with Disabilities Act (ADA) Claim Form (field #35) or field #24C of the Centers for Medicare & Medicaid Services (CMS) 1500 Claim Form.

As of December 1, 2014, eligible Medicaid Beneficiaries age 21 and older may receive up to \$750 annually in covered dental treatment under the adult preventive dental benefit. The annual benefit begins July 1 and continues through June 30 of the following year. The \$750 maximum benefit will

be based on claim payments under the **Healthy Connections** dental fee schedule. Utilization of sedation services will not consume the \$750 annual limit for the Adult Preventive Dental Benefit.

Providers should always check the Beneficiary's eligibility and service history for all beneficiaries. For adult beneficiaries ages 21 years and older, provider must also verify the available balance of the allowed \$750 annual limit prior to rendering services. The covered service that exhausts the maximum allowance will be paid based on the remaining dollars available. The remaining amount paid will be considered payment in full. SCDHHS will not reimburse for any service after the beneficiary's \$750 annual limit has been reached.

For denied covered services, providers can take one of the following actions:

- Resubmit the claim along with additional documentation or corrections as needed, or
- File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to Utilization Management section of this manual), or
- Provider will assume the cost for the services rendered with no billing to Medicaid or Beneficiary.

Note: *The billing of beneficiaries for covered services is prohibited.*

For services denied through PA process (including EPSDT services), providers can take one of the following actions:

If Medical Necessity has not been demonstrated:

- Resubmit the PA request along with additional documentation supporting Medical Necessity, or
- File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to Utilization Management section of this manual),
- Inform the Beneficiary that the service(s) were deemed not medically necessary; no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), and
 - Provider and beneficiary agree to forego with the service delivery, or
 - Provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement. In this case provider may proceed as follows:
 - › Provide the service to the Beneficiary free-of-charge, or
 - › Prior to the provision of the service the provider must obtain written agreement from the beneficiary indicating their willingness to assume financial responsibility for the non-medically necessary service(s). The agreement must detail the service(s) and the respective amount(s) that beneficiary is willing to assume responsibility for. If the

beneficiary assumes financial responsibility for the service, the provider may deliver the service and bill the beneficiary based on the provider's usual and customary charges.

If Medical Necessity documentation is missing or incomplete:

- Resubmit the PA request along with the required Medical Necessity documentation, or
- Provide the service(s) free-of-charge to the beneficiary with no billing to Medicaid.

If Service is not filed under EPSDT:

- Resubmit the PA request indicating "EPSDT" in the appropriate area on the form, or
- Provide the service free-of-charge to the Beneficiary and not bill Medicaid.

Note: *Claims submitted prior to receiving an approval for services requiring a Prior Authorization, will be denied. The billing of beneficiaries is prohibited while the PA process is on-going or until a Medical Necessity decision has been determined. All beneficiaries have the right to appeal any decision that delays, denies or reduces a dental benefit. Providers are prohibited from billing a beneficiary during the appeals process.*

For services denied through pre-payment review (PPR) process provider can take one of the following actions:

If Medical Necessity has not been demonstrated:

- Resubmit the claim along with additional documentation supporting Medical Necessity, or
- File for a reconsideration of the DentaQuest adverse decision (for reconsideration process and protocols refer to Utilization Management section of this manual), or
- Provider will assume the cost for the services rendered with No billing to Medicaid or Beneficiary.

If Medical Necessity documentation is missing or incomplete:

- Resubmit the claim along with additional documentation supporting Medical Necessity, or
- Provider will assume the cost for the services rendered with no billing to Medicaid or Beneficiary.

Note: *The billing of beneficiaries is prohibited for services denied through PPR.*

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UTILIZATION MANAGEMENT

GENERAL INFORMATION

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse providers must refer to the Provider Administrative and Billing Manual.

Additionally, Utilization Management policies specific for dental providers and dental services will be addressed in this section of the Dental Services Provider Manual.

DentaQuest conducts audits on behalf of SCDHHS Program Integrity following procedures and guidelines, as defined in the Utilization Management section of the Provider Administrative and Billing Manual.

SERVICES REQUIRING AUTHORIZATION

Authorizations are a utilization tool that require Participating Providers to submit “documentation” associated with certain dental services for a Beneficiary. Participating Providers will not be paid if this “documentation” is not furnished to DentaQuest. Participating Providers must hold the Beneficiary and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered) through PA or by PPR.

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria.

It is important not to submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. DentaQuest does not generally return x-rays and other supporting documentation. However, if you wish to have your x-rays returned, they must be submitted with a self-addressed stamped envelope.

Pre-Payment Review

Dental procedures that require review by DentaQuest for determination of Medical Necessity prior to reimbursement for the procedures. These procedures can be administered before determination of Medical Necessity is rendered but require submission of proper documentation for approval to process the claim.

The submission of “documentation” should include:

- Radiographs, detailed narrative, or other information where requested .

- Code on Dental Procedures and Nomenclature (CDT) codes on the ADA dental claim form.
- Current Procedural Terminology (CPT) codes on the CMS 1500 medical claim form, when applicable.

Claims with CDT procedure codes (D codes) must be submitted on an ADA approved claim form (year 2012 or newer). Claims with CPT procedure codes (medical codes) must be submitted on a CMS 1500 Claim Form, version (02/12).

Section 6: Reporting/Documentation and Appendix B: Documentation Required sections of this manual describe the necessary information to be submitted with the claim for PPR and/or to be maintained in the patient dental records.

Claims processed through PPR will be denied for one of the following reasons:

1. Medical Necessity Has Not Been Demonstrated

Upon review of the submitted documentation by a DentaQuest Dental Director, Medical Necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the Medical Necessity of the rendered service(s).

2. Medical Necessity Documentation Missing or Incomplete

Medical necessity has not been demonstrated due to a lack of or incomplete documentation.

Prior Authorization

Dental services that require an approval prior to the service being rendered must be listed on the ADA or CMS 1500 claim form and submitted with appropriate documentation that supports Medical Necessity no less than 15 days prior to the scheduled date of treatment. The requested service(s) will be reviewed by DentaQuest for determination of Medical Necessity. DentaQuest will review the request and render an approval or denial. The submitting office shall receive an authorization determination letter within 15 calendar days from the date the documentation is received by means of mail or fax and is available on the DentaQuest web portal. The approved authorization number must be submitted with the other required claim information after the treatment is rendered (For PA only). The PA number is valid for the specific treatment requested, one time and will expire six months from the date of issue.

Providers can submit PA requests via the following routes:

- Electronic: via DentaQuest web portal (www.dentaquest.com)
- Mail:
DentaQuest Authorizations
P.O. Box 2136
Columbia, SC 29202-2136
- Fax: +1 262 834 3589

DentaQuest will verify the member's eligibility if the service is covered and determine if your narrative supports the proposed treatment. Your request will then be considered "approved – pending". This means the service is approved based on the information you provided but does not guarantee payment. In order to receive payment, you must submit the claim and supporting documentation (please refer to Section 6: Reporting/Documentation and Appendix B: Documentation Required sections of this manual to verify required documentation for the submitted code). If the required documentation supports your initial PA submission, the service will be fully approved and eligible for payment.

Services that require PAs under the Health Connections benefits are:

- Non-State Plan covered services (EPSDT services): authorization for these services is issued by DentaQuest.
- Services delivered in an outpatient setting such as Operating Room (OR) and Ambulatory Surgical Center (ASC): authorization for these services is issued by DentaQuest.
- Services that require inpatient stay: authorization for these services is issued by KEPRO or MCO.

Expedited Prior Authorizations

For services requiring PA, there may be times when an Expedited Prior Authorization (EPA) is needed. The request for an EPA should indicate the urgent need and the providers must enter the full word "EXPEDITE" in the "Notes" field on the ADA Claim Form (field #35) or field #24C on the CMS 1500 Claim Form. PA requests made in urgent situations will be reviewed and the Medical Necessity determination will be made within 72 business hours of receipt. The request must include a narrative describing the urgent need for the service. Dental services requested through an Expedited Authorization must be listed on the ADA or CMS 1500 form and be submitted with appropriate documentation that supports the Medical Necessity. DentaQuest will verify the member's eligibility if the service is covered and determine if your narrative supports the proposed treatment. Your request will then be considered "approved – pending." This means the service is approved based on the information you provided but does not guarantee payment. In order to receive payment, you must submit the claim and supporting documentation (please refer to Section 6:

Reporting/Documentation and Appendix B: Documentation Required sections of this manual to verify required documentation for the submitted code). If the required documentation supports your initial PA submission, the service will be fully approved and eligible for payment.

To ensure a timely determination of your request for an Expedited Authorization (within 72 hours of receipt), we recommend the following submission methods:

- Email: Scan and email your urgent request to DQSCEmergency@DentaQuest.com. Please remember to use encryption technology when sending protected health information via email. Please use the fax option if your office does not have encryption capabilities.
- Fax: Fax your expedited request to: +1 800 521 1735

Note: *Please DO NOT submit an expedited PA via portal.*

If the PA request requires x-rays, please use one of the following methods to submit:

- National Electronic Attachment, LLC (NEA) — please note the NEA number on your claim form
- Scan the diagnostic image and email it to: DQSCEmergency@DentaQuest.com

If the provider does not have the capability to submit an NEA or image via email, the provider may still submit a PA request via portal, however this request will be processed within 15 calendar days of receipt.

Prior Authorization Reasons for Denial

Providers filing a PA or EPA for State Plan covered services must submit detailed documentation of Medical Necessity.

A PA or EPA request will be denied for one of the following reasons:

- **Medical Necessity has not been demonstrated:** Upon review of the submitted documentation by a DentaQuest Dental Director, Medical Necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the Medical Necessity of the requested service(s).
- **Medical Necessity documentation missing or incomplete:** Medical necessity has not been demonstrated due to a lack of or incomplete documentation.

Prior Authorization for Non-State Plan Covered Services

Providers must obtain a PA for all medically necessary non-State Plan covered services (EPSDT services) for all children under the age of 21. The authorization must have attached all documentation that supports the determination of Medical Necessity. Payment for approved EPSDT services must be accepted as payment in full.

EPSDT services exempt from PA are as follows:

- Service is delivered as an emergency, or
- Service is medically necessary to be delivered on the same day of diagnosis, or
- Service is part of the Initial Dental Encounter for the Foster Care Program (see details on the EPSDT Services within the Benefit Criteria and Limitations, Appendix B of this manual).

EPSDT services that are exempt from PA must meet the Medical Necessity for the service and will be processed through PPR.

DentaQuest will review all valid EPSDT PA submissions. Approved PA's must have the appropriate claim form before it will be reviewed. A denial of a PA or EPA request for EPSDT services will be for one of these three reasons:

1. Medical Necessity Has Not Been Determined

Upon review of the submitted documentation by a DentaQuest Dental Director, Medical Necessity has not been demonstrated. Medical necessity denials occur when the supporting documentation for the service was submitted but the content of the documentation was not sufficient to support the Medical Necessity of the requested service(s).

2. Medical Necessity Documentation Missing or Incomplete

Medical Necessity has not been demonstrated due to a lack of or incomplete documentation.

3. Service Not Filed Under EPSDT

EPSDT review requires that "EPSDT" be indicated on the PA request. There is either no indication of EPSDT on the request, or the appropriate area on the PA request form is not marked.

Authorization for Services Delivered in an Outpatient Setting

Outpatient setting includes OR and ASCs. The Participating dental provider should submit the PA request to DentaQuest. The PA request must include the procedure codes that the provider is planning to render as well as the procedure code that identifies the utilization of the ASC/OR facility for the services requested. PA request must indicate the appropriate POS code. PA request must include all appropriate documentation such as a detailed narrative of Medical Necessity, radiographs and/or other supporting documentation that will assist in the determination of Medical Necessity. DentaQuest will review the services for Medical Necessity and render an approval or denial for each including the use of the facility. Receipt of the approved authorization from DentaQuest allows a dental provider to schedule with the facility. Participating providers do not need to seek authorization from the beneficiary's MCO.

Authorization for Services That Require Inpatient Stay

DentaQuest will not issue and will deny any authorization that includes at least one procedure code that requires inpatient stay.

Authorization for services that require inpatient stay will be issued only by KEPRO or the Beneficiary's MCO. Dental provider must coordinate with the hospital, where these services will be rendered, to obtain the appropriate authorization.

Providers can view the CMS rule for inpatient only services at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3941CP.pdf>

A list of these services can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

CLAIMS RECONSIDERATION

Request for Reconsideration

Participating Providers that disagree with determinations made by DentaQuest Dental Directors may submit a written Request for Reconsideration to DentaQuest that specifies the nature and rationale for the Reconsideration. Provider must complete the Request for Reconsideration Form (link found in DentaQuest Web Portal under "Related Documents") and follow the instructions listed on the form. This Request and additional support information must be sent to DentaQuest at the address below within 30 calendar days of the date of receipt of the notice of adverse action or 30 calendar days from receipt of the remittance advice reflecting the denial, whichever is later.

DentaQuest, LLC

Attention: Utilization Management/Provider Appeals

PO Box 2906

Milwaukee, WI 53201-2906

Requests for reconsideration can also be faxed to: +1 262 834 3452

DentaQuest will respond in writing to the Provider with its decision to either uphold or overturn its original decision within 30 calendar days of receipt of the provider's Request for Reconsideration. If DentaQuest upholds its original decision the Provider may request a State Fair Hearing with SCDHHS. For details on how to request a State Fair Hearing please refer to the Provider Administrative and Billing Manual.

BENEFICIARY GRIEVANCES AND APPEALS

Beneficiary Complaints (Grievances)

Beneficiaries may submit complaints to DentaQuest telephonically or in writing on any **Healthy Connections** dental program issues other than decisions that deny, delay or reduce dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, Provider care and treatment, or administrative issues. DentaQuest will respond to Beneficiary complaints immediately, if possible, however, each complaint will be addressed no later than 30 calendar days from the date the complaint (grievance) is received.

Beneficiary Appeals

Beneficiaries have the right to appeal any denial or adverse decision DentaQuest has made to deny, reduce or delay dental services. Beneficiaries may request assistance with filing an appeal by contacting DentaQuest at: +1 888 307 6552. Beneficiaries may send appeal requests to DentaQuest at the address listed above within 30 calendar days of receipt of the adverse decision notice. DentaQuest will respond in writing to Beneficiary appeals within 30 days of the date of receipt, or within three days if the condition needs immediate attention. If DentaQuest upholds its original decision the Beneficiary may request a State Fair Hearing with the SCDHHS. For details on how to request a State Fair Hearing please refer to the Provider Administrative and Billing Manual.

Beneficiary complaints and/or appeals should be directed to:

DentaQuest, LLC
Healthy Connections
Attention: Complaints and Appeals
PO Box 2906
Milwaukee, WI 53201-2906

FRAUD AND ABUSE

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse for the **Healthy Connections** 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.

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

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

Beneficiary Fraud: If a Provider suspects a Beneficiary of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to SCDHHS.

DentaQuest will work closely with SCDHHS' Program Integrity to ensure that Medicaid funds are used effectively, efficiently and in compliance with applicable State and federal laws and policies.

If at any time you suspect a health care Provider or a Beneficiary is using the Medicaid program in an abusive or fraudulent manner, please contact the Program Integrity Medicaid Fraud and Abuse Hotline at +1 888 364 3224 or fraudres@scdhhs.gov.

6

REPORTING/DOCUMENTATION

General policies for treatment records requirements and documentation are detailed in the Provider Administrative and Billing Manual.

Additionally, dental providers must also comply with the following requirements:

The Dental Treatment Record

The treatment record is a legal document and it must contain the patient's chief complaint, diagnosis, and documentation of services performed. Documentation consists of a complete and accurate treatment record and accountability of other special services.

No other documentation (with the exception of hospital records) will be accepted in lieu of a treatment record. This includes PA forms, ledger cards, claim forms, computer records, etc. ***Claims paid for Medicaid services that are not adequately documented in the treatment record are subject to repayment by the Medicaid provider.*** The dental provider's treatment record on each Beneficiary must substantiate the need for services, including all findings and information supporting Medical Necessity and detailing all treatment provided. As a condition of participation in the Medicaid dental program, dental providers are required to maintain and provide access to records that fully disclose the Medical Necessity for treatment and the extent of services provided to Medicaid patients. SCDHHS requires that documentation (including appropriate pre- and post-treatment radiographs, copies of laboratory prescription slips and laboratory tests [i.e., pathology reports]) be included in the Beneficiary's treatment record.

Medicaid providers are required to maintain *on site*, all medical and fiscal records pertaining to Medicaid beneficiaries for a period of five years to facilitate audits and reviews of the patient's dental record. This requirement is in addition to all other record retention requirements included in State and federal laws.

The following guidelines have been established to assist Provider offices with keeping diligent and complete dental records.

1. Organization
2. The dental record should have areas for documentation of the following information:
 - A. Registration data including a complete health history
 - B. Medical alert predominantly displayed inside chart jacket
 - C. Initial examination data

- D. Radiographs
 - E. Periodontal and occlusion 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)
3. The design of the dental record should 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
4. The design of the dental record should ensure that all permanent components are attached or secured within the record.
5. The design of the dental record should ensure that all components are readily identifiable to the Beneficiary (i.e., first name, last name and identification number on each page).
6. The organization of the dental record system should require that unique records are assigned to each patient.
7. Content — The dental record should contain the following:
- A. Adequate documentation of registration information which requires entry of these items:
 - i. Beneficiaries' first and last name
 - ii. Date of birth
 - iii. Sex
 - iv. Address
 - v. Telephone number

- vi. Name and telephone number of the person to contact in case of emergency
8. An adequate health history that requires documentation of these items:
 - A. Current medical treatment
 - B. Significant past illnesses
 - C. Current medications
 - D. Drug allergies
 - E. Hematologic disorders
 - F. Cardiovascular disorders
 - G. Respiratory disorders
 - H. Endocrine disorders
 - I. Communicable diseases
 - J. Neurologic disorders
 - K. Signature and date by patient
 - L. Signature and date by reviewing dentist
 - M. History of alcohol and/or tobacco usage including smokeless tobacco
 9. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
 - A. Significant changes in health status
 - B. Current medical treatment
 - C. Current medications
 - D. Dental problems/concerns
 - E. Signature and date by reviewing dentist
 10. A conspicuously placed medical alert notification that documents highly significant terms from health history. These items are:
 - A. Health problems which contraindicate certain types of dental treatment

- B. Health problems that require precautions or pre-medication prior to dental treatment
 - C. Current medications that may contraindicate the use of certain types of drugs or dental treatment
 - D. Drug sensitivities
 - E. Infectious diseases that may endanger personnel or other patients
11. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
- A. Blood pressure (Recommended)
 - B. Head/neck examination
 - C. Soft tissue examination
 - D. Periodontal assessment
 - E. Occlusion classification
 - F. Dentition charting
12. Adequate documentation of the Beneficiaries' status at subsequent periodic/recall examinations which is dated and requires descriptions of changes/new findings in these items:
- A. Blood pressure (Recommended)
 - B. Head/neck examination
 - C. Soft tissue examination
 - D. Periodontal assessment
 - E. Dentition charting
13. Radiographs which are:
- A. Identified by first and last name
 - B. Dated
 - C. Designated by left and right side
 - D. Mounted (if intraoral films)

14. An indication of the Beneficiaries' clinical problems/diagnosis
15. 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)
16. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
 - A. Periodontal pocket depth
 - B. Furcation involvement
 - C. Mobility
 - D. Recession
 - E. Adequacy of attached gingiva
 - F. Missing teeth
17. An adequate documentation of the Beneficiaries' oral hygiene status and preventive efforts which requires entry of these items:
 - A. Gingival status
 - B. Amount of plaque
 - C. Amount of calculus
 - D. Education provided to the Beneficiary
 - E. Beneficiary receptiveness/compliance
 - F. Recall interval
 - G. Date
18. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
 - A. Provider to whom consultation is directed

B. Information/services requested

C. Consultant's response

19. Adequate documentation of treatment rendered which requires entry of these items:

A. Date of service/procedure

B. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth-by-tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.

C. Type and dosage of anesthetics and medications given or prescribed.

D. Localization of procedure/observation (tooth number, quadrant, etc.).

E. Signature of the Provider who rendered the service.

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

A. Examination

B. Treatment plan

C. Treatment status

21. Compliance:

A. The dental record has one explicitly defined format that is currently in use.

B. There is consistent use of each component of the dental record by all staff.

C. The components of the dental record that are required for complete documentation of each Beneficiary's status and care are present.

D. Entries in the dental records are legible.

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

Documentation Required

Documentation in the treatment record must justify the need for the procedure performed due to Medical Necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the affected tooth, the adjacent and opposing teeth if applicable, substantiating any pathology or caries present, are required for treatment record.

Note: *Intraoral photographs may be allowed if the patient's physical and/or mental status prohibits the provider from obtaining diagnostic radiographs. A detailed narrative with justification of sufficient efforts taken to obtain radiographs must be documented in the patient's records.*

Post-operative radiographs (when applicable) are also required for the treatment record.

Covered dental services that require PPR or PA require documentation of Medical Necessity to be submitted with the claim or PA for review. Documentation of Medical Necessity includes, but is not limited to a detailed narrative, diagnostic radiographs, intraoral photographs, periodontal charting, relevant medical or dental conditions; and any other relevant documentation that would support the Medical Necessity for the service. Please refer to the definitions section within this manual for the definition of Medically Necessary. Please refer to Section 6: Documentation Required for each procedure category in Appendix B of this manual.

Failure to submit the required documentation may result in a disallowed request and/or denied payment of a claim related to that request.

- PA is required for non-State Plan covered services, services delivered in an outpatient setting (ASC/OR) or services that require inpatient stay.
- Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation with the claim form.

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the Treatment Record section within the Reporting/Documentation section of this manual for additional detail.

For all procedures, every Participating Provider in the **Healthy Connections** program is subject to random chart/treatment audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits or removal of the Provider from the **Healthy Connections** Network.

Documenting and Reporting

Tooth Numbering

DentaQuest recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by “AS through TS” for primary teeth and tooth numbers “51” to “82” for permanent teeth. These codes must be referenced in the patient’s file for record retention and review.

See the American Dental Association’s *Current Dental Terminology* manual for additional information on proper designation of primary, permanent and supernumerary teeth.

Tooth Surfaces

DentaQuest recognizes tooth surfaces M – Mesial, D – Distal, and L – Lingual for all primary and permanent teeth.

The appropriate restored surfaces on the following teeth must be designated either O – Occlusal or B – Buccal:

- Permanent Posterior Teeth: # 1, 2, 3, 4, 5, 12, 13, 14 to 21, 28, 29, 30, 31, and 32
- Primary Posterior Teeth: # A, B, I, J, K, L, S and T

The appropriate restored surfaces on the following teeth must be designated either I – Incisal or F – Facial:

- Permanent Anterior Teeth: # 6, 7, 8, 9, 10 11, 22, 23, 24, 25, 26, and 27
- Primary Anterior Teeth: # C, D, E, F, G, H, M, N, O, P, Q, and R

Quadrants and Arches

To report and document services that require indication of quadrants or arches, provider must use the following indicators:

- Quadrants:
 - 10 — Upper Right Quadrant
 - 20 — Upper Left Quadrant
 - 30 — Lower Left Quadrant
 - 40 — Lower Right Quadrant

- Arches:
 - 00 — entire oral cavity
 - 01 — maxillary arch
 - 02 — mandibular arch

Procedures

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT or American Medical Association CPT Code list or those as defined as a Covered Benefit. To purchase copies of the code books please refer to the Provider Administrative and Billing Manual Appendices section.

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

All the above indicators and the approved procedure codes must be referenced in the patient's file for record retention and review as well as in the claim or PA forms.

All dental services performed must be recorded in the patient record, which must be available as required by the Participating Provider Agreement.

7

BILLING GUIDANCE

GENERAL INFORMATION

General Billing Guidance such as Usual and Customary Rates; Timely Filing; Beneficiary Co-Payments; Third Party Liability and Coordination of Benefits (COB); Adjustments and Refunds; Remittance Advices; Electronic Fund Transfer etc. are detailed in the Provider Administrative and Billing Manual.

Additional Billing Guidance specific to dental services rendered by dental providers will be covered in this manual. SCDHHS requires dental providers to submit all claims with the most current coding standard maintained by ADA and AMA. In addition, all paper claims with CDT procedure codes (“D” Codes) must be submitted on the current approved ADA Claim Form (year 2012 or newer) and all CPT procedure codes must be submitted on the CMS 1500 Claim Form (version 02/12), when applicable.

Dental providers must file all the claims to DentaQuest, the SCDHHS Dental ASO.

FILING CLAIMS

General policies for claim filing and claim completion instructions are detailed in the Provider Administrative and Billing Manual. Additional claim filing requirements for dental providers are detailed below:

Filing Options

Dental Providers may choose to submit their claims to DentaQuest in one of the following formats:

- Paper format
- Electronic format in one of the following:
 - Via DentaQuest’s web portal (www.dentaquest.com).
 - Via clearinghouses.
 - Via HIPAA compliant 837D or 837P File.

Paper Format

Paper Claims or PAs should be mailed to the following address:

DentaQuest, LLC
P.O. Box 2136
Columbia, SC 29202-2136

- Mail it to the attention of:
 - “**Claims**” — for paper claims
 - “**Authorizations**” — for paper PAs
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.
- If documentation is required, please do not submit original x-rays especially if they are the only diagnostic record for your patient. Duplicate films and x-ray copies of diagnostic quality, including paper copies of digitized images are acceptable. DentaQuest does not generally return x-rays and other supporting documentation. However, if you wish to have your x-rays returned, they must be submitted with a self-addressed stamped envelope.

Electronic Format

- Via DentaQuest’s Provider Web Portal:
 - Participating Providers may submit claims or PAs directly to DentaQuest by utilizing the Provider Web Portal on DentaQuest website.
 - › Log on to www.dentaquest.com
 - › Click on the “Dentist” icon
 - › Choose “South Carolina” and press “go”
 - › Log in using your password and ID
 - › Select “Claims/Prior authorizations”
 - › Select “Dental Claim Entry” or “Dental Prior-Auth Entry”
 - › Attach electronic files (if applicable) such as x-rays in jpeg format, reports, charts, etc.

First time users will have to register by utilizing the Business’s NPI or TIN, State and zip code. For assistance in submitting claims or PAs through the DentaQuest web portal, please contact Customer Service Center at +1 888 307 6553.

- Via Clearinghouse

— Participating Providers may submit their claims to DentaQuest through:

- › Emdeon: +1 888 255 1293
- › Tesia: +1 800 724 7040
- › EDI Health Group: +1 800 576 6412
- › Secure EDI: +1 877 466 9656
- › Mercury Data Exchange: +1 866 633 1090

Additional clearinghouses may be added in the future. The DentaQuest Government Payer ID is CX014 for electronic claim filing. If your software vendor does not accommodate the Payer ID, be sure that the following address is included on the claims:

DentaQuest Government
P.O. Box 2136
Columbia, SC 29202-2136

Please contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. The provider's software vendor should be able to provide with any information needed to ensure that the provider's submitted claims are forwarded to DentaQuest.

- Via HIPAA Compliant 837D and 837P File

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

Electronic Attachments

DentaQuest accepts dental radiographs electronically via FastAttach™ for PA requests and PPR. DentaQuest, in conjunction with NEA, allows Participating **Healthy Connections** Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure internet lines for radiographs, periodontal charts, intraoral pictures, narratives and explanation of benefits (EOBs).

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

For more information or to sign up for FastAttach™ go to www.nea-fast.com or call NEA at: +1 800 782 5150.

In order to submit claims to DentaQuest through a clearinghouse or through a direct integration, the integration needs to be reviewed to assure that it is in compliance with the revised HIPAA compliant 837D or 837P format. This information can be found on the 837D or 837P Guides located on the Provider Web Portal at www.dentaquest.com.

Note: Copies of DentaQuest’s HIPAA policies are available upon request by contacting DentaQuest’s Customer Service Center at +1 888 307 6553 or via email at denelig.benefits@dentaquest.com.

Claim Completion Instructions

- ADA Claim Form (2012) Completion Instructions:
 - American Dental Association provides general instructions for completing the ADA Claim Form 2012. Those instructions can be accessed at: http://www.ada.org/~media/ADA/Member%20Center/Files/ada_dental_claim_form_completion_instructions_2012.ashx
- CMS 1500 Claim form Completion Instructions:
 - General instructions for completing the CMS 1500 Claim form are detailed in the Provider Administrative and Billing Manual.
- Additionally, SCDHHS requires that a claim form filed by a dental provider must:
 - Contain the Beneficiary name, identification number and date of birth. If the Beneficiary identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment. Contain the valid Provider NPI numbers, which must be entered properly and in their entirety in order for claims to be accepted and processed accurately. For claims with a Group NPI as the “Billing” provider, the claim must be submitted with both the Group (Type 2) NPI under “Billing Provider and Individual (Type 1) NPI under “Treating Provider.” These numbers are not interchangeable and could cause the claim to be returned as non-compliant.
 - Contain an acceptable Provider signature. Refer to the Provider Administrative and Billing Manual for a list of acceptable signatures; “Signature on File” is acceptable. DentaQuest requires that dental services provided will be authenticated by the provider. Acceptable method used for authentication shall be handwritten, signed initials and/or rubber stamp signatures.
 - Contain the Provider and office location information, which are clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist’s name cannot be clearly identified. Please include a typed dentist (practice) name and the address location where the services were rendered.

- Contain an accurate POS, approved and maintained by CMS. The POS codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. The SCDHHS requires POS codes for all submitted CMS 1500 and ADA Claim Forms. The 2012 ADA Claim Form (Field 38) and CMS 1500 form (Field 24 B) allow for the POS entry.
- For a complete listing of POS codes please visit CMS website.
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- Contain the date of service for each service line submitted.
- Identify all services by either an approved and valid ADA dental or AMA professional codes as published in current CDT and CPT books, respectively.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification. Missing tooth, surface, quadrant or arch identification codes may result in the delay or denial of the claim.

Claim Filing Instructions by Place of Service or Benefit

Claim Submission for Emergency or Repair of Traumatic Injury Surgical Services

Filing a claim for the provision of the Emergency or Repair of Traumatic Injury Surgical Services, providers must use the appropriate claim form. Dental services (CDT Procedure codes) must be filed on the ADA Claim form (2012 or newer) and medical services (CPT procedure codes) must be filed on the CMS 1500 Claim Form. Medical services are allowed to be performed only by Oral Surgeons.

Medically Necessary Oral and Maxillofacial diagnostic and surgical services rendered for emergency or repair of traumatic injury will not consume the \$750 annual maximum allowed for adult beneficiaries under the Preventive Dental Benefit, as long as claims for treatment under this category is appropriately submitted.

When filing a claim or PA for the provision of the Oral and Maxillofacial Emergency Services providers must indicate on the claim:

- The word “EMERGENCY” in the “Notes” field when filing electronically.
- The word “EMERGENCY” in the “Remarks” field # 35 of the ADA Claim Form (2012 or newer).
- Check off field #24C on the CMS 1500 Claim Form (version 02/12).

Claim Submission for Exceptional Medical Conditions

Medically necessary dental services rendered in preparation for or during treatment of Exceptional Medical Conditions will not consume the \$750 annual maximum allowed for adult beneficiaries under the Preventive Dental Benefit as long as claims for treatment under this category is appropriately

submitted. Please refer to the Exceptional Medical Conditions section for details on services covered, criteria, and documentation required for review for these services.

When filing claims for the provision of dental services in preparation for or during the treatment of Exceptional Medical Conditions, providers must indicate on the claim the word:

- “MEDICAL CONDITION” in the “Notes” field when filing electronically.
- “MEDICAL CONDITION” in the “Remarks” field #35 of the ADA Claim Form (2012 or newer).
- “MEDICAL CONDITION” within Field 19 on the CMS 1500 Claim Form.

Claim/PA Submission for EPSDT Services

Planned EPSDT Services

When filing a PA or a claim for the provision of medically necessary services rendered under the EPSDT benefit, providers must indicate the “EPSDT” Field on the claim forms.

- EPSDT Box in Field 1 — for ADA Claim Forms
- Field #24H — for CMS 1500 Forms

All claims or PAs submitted for the Non-State Plan covered codes will be systemically denied if the EPSDT indicator is not selected.

EPSDT Services Delivered as an Emergency

EPSDT Services delivered when medically necessary as an emergency, will be processed through PPR. The claim filed for the provision of medically necessary services rendered under the EPSDT benefit in these cases, must indicate the following:

- *ADA Claim Form:*
 - EPSDT Box in Field 1, and
 - The word “EMERGENCY” in the Remarks field # 35 of the ADA paper claim form or Notes Field if filed electronically,
- *CMS 1500 Claim Form:*
 - Check off Field #24H, and
 - Check off Field #24C

All claims submitted for the Non-State Plan covered codes will be systemically denied if the EPSDT indicator is not selected.

EPSDT Services — Initial Dental Encounter for Foster Children

Providers who will render the South Carolina Department of Social Services (DSS) required Initial Dental Encounter, should file their claim as follows:

- Check EPSDT box in field 1 of the ADA Claim Form, and
- Indicate “FOSTER CARE” in the Remarks Field #35 of the ADA Claim Form, or in the Notes Field when filing electronically.

All claims submitted for the Non-State Plan covered codes will be systemically denied if the EPSDT indicator is not selected.

Claim Submission for Services Performed in an Outpatient Setting (ASC/OR)

All services rendered in an ASC or OR facility require PA. The Claim must indicate the proper POS code for the ASC or OR. Requirements to obtain approval are outlined in this manual. All claims for approved services rendered in an ASC/OR, regardless of the Beneficiary’s managed care enrollment, should be sent directly to DentaQuest for processing. Dental provider must include the DentaQuest approved PA number (on the appropriate section of the claim form) when filing a claim for services performed in the ASC/OR.

Claim Submission for Services That Require Inpatient Stay

DentaQuest will deny claims filed for services that require inpatient stay. The authorizations for these services will only be issued by KEPRO or the beneficiary’s MCO. Reimbursement for these services are included in the medical payment paid to the hospital.

Claim Submission with Standard Coordination of Benefits (COB)

When filing a claim that requires coordination of benefit, providers must indicate the primary Insurance information and payment on the claim form.

- On ADA Claim Forms — providers must include:
 - The South Carolina three-digit carrier code or codes in Field 9, and
 - The policy number or numbers in Field 8, and
 - The amount paid or amounts paid in Field 11.
- On CMS 1500 Claim Forms, provider must include:
 - The carrier code or codes in Field 9a, and
 - The policy number or numbers in Field 9d, and
 - The amount paid or amounts paid in Field 10d.

- For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field.

When a primary carrier or carriers' payment meets or exceeds the SCDHHS dental service fee schedule, SCDHHS will consider the claim paid in full and no further payment will be made on the claim. The Provider may not bill the Beneficiary for any difference between SCDHHS' payment and the Provider's billed amount, or request to share in the cost through a co-payment or similar charge. Medicaid beneficiaries with private insurance are not to be charged the co-payment amount of the primary payers.

Please contact Customer Service at +1 888 307 6553 with any questions regarding the submission of other carrier information to DentaQuest.

ELECTRONIC REMITTANCE STATEMENTS

Healthy Connections Participating Dental Providers may access their EOBs/remittance statements electronically via DentaQuest's Provider Web Portal. The remittance statements include patient information and the allowable fee for each service rendered.

Providers may access their remittance statements by following these steps:

- Login to the Portal at www.dentaquest.com,
- Under the Documents header, select Claim Search,
- Click on the Explanation of Benefits button to display the remittance notice,
- Click on the View button at the right end of the specific remittance that you would like to view,
- The EOB will display on the screen in a PDF format.

In order to ensure timely, accurate remittances to each Participating **Healthy Connections** Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Beneficiary eligibility, procedure codes and dentist identifying information. A DentaQuest Claim Resolution Specialist analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Center at +1 888 307 6553 with any questions you may have regarding claim submission or your remittance.

An EOB statement accompanies the remittance advice posted on the Provider Web Portal. This report includes patient information and the allowable fee for each service rendered.

APPENDIX A

ADDRESS AND TELEPHONE NUMBERS

DentaQuest's South Carolina Office

1333 Main Street, Suite 603
Columbia, SC 29201

Provider Call Center

Phone: +1 888 307 6553

Fax: +1 262 834 3589

IVR: +1 888 307 6553

Email:

Claims Questions: denclaims@dentaquest.com

Eligibility or Benefit Questions: denelig.benefits@dentaquest.com

Beneficiary Call Center

Phone: +1 888 307 6552

TDD (Hearing Impaired): +1 800 466 7566

Special Needs Beneficiary Services: +1 800 660 3397

SCDHHS Fraud and Abuse Hotline

Phone: +1 888 364 3224

Email: fraudres@scdhhs.gov

Dental claims should be mailed to:**DentaQuest, LLC — Claims**

P.O. Box 2136

Columbia, SC 29202-2136

Electronic Claims should be sent:

Via the web: www.dentaquest.com

Via Clearinghouse

DentaQuest Systems Corporation

P.O. Box 2906

Milwaukee, WI 53201-2906

Authorization requests should be sent to:

DentaQuest, LLC — Authorizations

P.O. Box 2136

Columbia, SC 29202-2136

PAs for hospital outpatient, OR, or ASC cases should be sent to:

DentaQuest, LLC — Authorizations

P.O. Box 2136

Columbia, SC 29202-2136

Requests for Reconsideration Should Be Sent to:

DentaQuest, LLC

Utilization Management/Provider Appeals

P.O. Box 2906

Milwaukee, WI 53201-2906

or faxed to: +1 262 834 3452

Beneficiary Grievance and Appeals

DentaQuest, LLC

Complaints and Appeals

P.O. Box 2906

Milwaukee, WI 53201-290

APPENDIX B

BENEFITS CRITERIA AND LIMITATIONS

The clinical criteria are used for making Medical Necessity determinations for PAs, post-payment review and retrospective review. In addition, please review the general “Clinical Criteria” in this manual and the Benefit limitations on a per code basis.

The criteria outlined in SCDHHS’ Dental Office Reference Manual are based around procedure codes as defined in the American Dental Association CDT Manual and the American Medical Association CPT Manual.

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 South Carolina requirements as well. They are designed as a *guideline* 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.

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the “Patient Record” and “Documentation Required” sections for additional detail.

The reimbursement fee for a dental procedure is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, surgical trays, equipment, topical or local anesthesia and post-operative care.

The following criteria are intended to provide a better understanding of the decision-making process for reviews. This section provides some generalized criteria, there may be additional program specific criteria outlined by SCDHHS regarding treatment. Therefore, it is essential you review the Criteria, Reporting/Documentation and Benefit Limitations sections of this manual for each procedure category before providing any treatment.

The **Healthy Connections** Dental benefit is comprised of:

- State Plan-Covered Services:
 - Preventive Dental Benefit
 - Emergency or Repair of Traumatic Injury:
 - › Oral and Maxillofacial Diagnostic and Surgical Services

- Services for Exceptional Medical Conditions
- Non-State Plan Covered Services:
 - EPSDT Services

This manual will provide the criteria, documentation required and benefit limitations for each dental benefit and procedure category.

STATE PLAN COVERED SERVICES

Preventive Dental Benefit

Diagnostic Services

Criteria

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health. Reimbursement fee for the diagnostic dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

A medically necessary problem-focused exam (D0140) is only allowed with diagnostic services and/or non-planned treatment services that address the reason for the exam. The placement of dental sealants is also allowable on the same date of service as the medically necessary problem-focused exam (D0140), however there must be documentation of Medical Necessity justifying the exam. A problem-focused exam for the sole purpose of placing dental sealants is NOT allowed.

The maximum amount paid for individual or sets of radiographs taken on the same day will be limited to the allowance for a full mouth series. When individual or sets of radiographs are bundled to this allowance, they are payable as D0210.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if SCDHHS determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Radiographs that do not fit the policy description will not be reimbursed for, or if already paid for, SCDHHS will recoup the funds previously paid. SCDHHS utilizes the guidelines published by the U.S. Department of Health and Human Services (DHHS), Center for Devices and Radiological Health (CDRH). However, please refer to the Benefit Limitations section.

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

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record requirements.

Benefit Limitations

Diagnostic							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D0120	Periodic evaluation-established patient	Child	0-20		One of D0120, D0145 per 6 months per patient	No	No
		ID/RD Waiver	21+		One of D0120, D0145 per 6 months per patient	No	No
		Adult	21+		One of D0120, per 12 months per patient	No	No
D0140	Limited oral evaluation-problem focused	Child	0-20		Two of (D0140) per 12 month(s) per Provider or location.	No	No
		ID/RD Waiver	21+		Two of (D0140) per 12 Month(s) per Provider or location.	No	No
		Adult	21+		Two of (D0140) per 12 Month(s) per patient.	No	No
D0145	Oral evaluation for children >3 years of age and counseling with primary caregiver	Child	0-2		One of (D0120, D0145) per 6 Month(s) per Provider or location	No	No
		ID/RD Waiver	<i>Not applicable</i>				
		Adult	<i>Not applicable</i>				
D0150	Comprehensive Oral Evaluation-new or established patient	Child	3-20		One of (D0150) per 36 Month(s) per Provider or Location. Not allowed within 6 months of D0120 or D0145 for same provider or location	No	No
		ID/RD Waiver	21+		One of (D0150) per 36 Month(s) per Provider or location. Not allowed within 6 months of D0120 or D0145 for same provider or location	No	No
		Adult	21+		One of (D0150) per 36 Month(s) per patient. Not allowed within 12 months of D0120.	No	No

Diagnostic							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D0210	Intraoral - complete series of radiographic images	Child	2-20		One of (D0210, D0330) per 36 months per patient	No	No
		ID/RD Waiver	21+		One of (D0210, D0330) per 36 months per patient	No	No
		Adult	21+		One of (D0210, D0330) per 36 months per patient	No	No
D0220	Intraoral - periapical first radiographic image	Child	2-20		One of (D0220) per 1 day(s) per patient	No	No
		ID/RD Waiver	21+		One of (D0220) per 1 day(s) per patient	No	No
		Adult	21+		One of (D0220) per 1 day(s) per patient	No	No
D0230	Intraoral - periapical each additional radiographic image	Child	2-20		Three of (D0230) per 1 day(s) per patient	No	No
		ID/RD Waiver	21+		Three of (D0230) per 1 day(s) per patient	No	No
		Adult	21+		One of (D0230) per 1 day(s) per patient	No	No
D0240	Intraoral - occlusal radiographic image	Child	2-20		Two of (D0240) per 12 Month(s) per patient	No	No
		ID/RD Waiver	21+		Two of (D0240) per 12 Month(s) per patient	No	No
		Adult	21+		<i>Not a covered service</i>		
D0270	Bitewing - single radiographic image	Child	2-20		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		ID/RD Waiver	21+		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		Adult	21+		<i>Not a covered service</i>		
D0272	Bitewings - two Radiographic images	Child	2-20		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		ID/RD Waiver	21+		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		Adult	21+		One of (D0272, D0274) per 12 month(s) per patient	No	No
D0274	Bitewings - four radiographic images	Child	2-20		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		ID/RD Waiver	21+		One of (D0270, D0272, D0274) per 6 month(s) per patient	No	No
		Adult	21+		One of (D0272, D0274) per 12 month(s) per patient	No	No
D0330	Panoramic radiographic image	Child	6-20		One of (D0210, D0330) per 36 Month(s) Per patient. Oral surgeons are allowed one additional usage of D0330 per beneficiary within the 36-month period.	No	No
		ID/RD Waiver	21+		One of (D0210, D0330) per 36 month(s) per patient	No	No
		Adult	21+		One of (D0210, D0330) per 36 month(s) per patient	No	No

Preventive Services

Criteria

Reimbursement fee for the preventive dental procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary’s representative. Multistage procedures are reported and may be reimbursed upon completion. The completion date for fixed space maintainers is the cementation date regardless of the type of cement utilized.

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

Space Maintainers

- Space maintainers are performed to prevent tooth movement and maintain the space for eruption of a permanent tooth when the deciduous tooth has been lost prematurely.
- The procedure is reimbursable once per lifetime and includes any follow-up care and/or re-cementing, if necessary. The space maintainer must be cemented prior to submitting a claim for reimbursement.
- Space maintainers are not reimbursable when the eruption of the permanent tooth is imminent.
- A bilateral fixed space maintainer (D1516 or D1517) is allowed and reimbursable when there is no service history of any space maintainers for the same arch. Additionally, the bilateral fixed space maintainer (D1516 or D1517) placed on the same arch with a service history of one unilateral fixed space maintainer (D1510) will be allowed and reimbursed at the D1510 rate. Reimbursement for a bilateral fixed space maintainer placed on the same arch with a service history of two unilateral fixed space maintainers is not allowed.

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general dental treatment record requirements.

Benefit Limitations

Preventive							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D1110	Prophylaxis adult	Child	12-20		One of (D1110, D1120) per 6 month(s) per patient	No	No
		ID/RD Waiver	21+		One of (D1110) per 6 month(s) per patient	No	No
		Adult	21+		One of (D1110) per 12 month(s) per patient	No	No

Preventive								
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review	Prior Authorization	
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan			
D1120	Prophylaxis child	Child	0-11		One of (D1110, D1120) per 6 month(s) per patient	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not applicable				
D1206	Topical Fluoride Varnish	Child	0-20		One of (D1206, D1208) per 6 month(s) per patient	No	No	
		ID/RD Waiver	21+	One of (D1206, D1208) per 6 month(s) per patient			No	No
		Adult	21+	Not a covered service				
D1208	Topical Fluoride-excluding varnish	Child	0-20		One of (D1206, D1208) per 6 month(s) per patient	No	No	
		ID/RD Waiver	21+	One of (D1206, D1208) per 6 month(s) per patient			No	No
		Adult	21+	Not a covered service				
D1351	Sealant- per tooth	Child	5-14	2, 3, 14, 15, 18, 19, 30, 31	One (D1351) per 36 month(s) per patient per tooth	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not a covered service				
D1510	Space maintainer-fixed, unilateral	Child	0-20	Per Quad 10, 20, 30, 40	One of (D1510) per lifetime per patient per quadrant	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not a covered service				
D1516	Space maintainer-fixed, bilateral maxillary	Child	0-20		One of (D1516) per lifetime per patient	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not a covered service				
D1517	Space maintainer-fixed, bilateral mandibular	Child	0-20		One of (D1517) per lifetime per patient	No	No	
		ID/RD Waiver	21+	Not applicable				
		Adult	21+	Not a covered service				

Restorative Services

Criteria

Reimbursement fee for the restorative procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite,

liners, bases, temporary or protective restorations, direct and indirect pulp caps, curing, polishing, supplies, trays, equipment, topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Restorative Fillings

Payment is made for restorative fillings based on the number of surfaces restored, not on the number of restorations per surface, or per tooth. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Restoration on the same surface of the same tooth is allowed as follows:

- Children — once per 36 months per provider or provider location,
- ID/RD Waiver — once per 36 months per provider or provider location,
- Adults — once per 36 months per patient.

Additionally, reimbursement for a tooth restored within a 12-month timeframe after the placement of a dental sealant or a restoration by the same provider or provider location is subject to payment adjustment based on the initial service, regardless of the surface combinations involved.

Reimbursement for restorative treatment of retained primary teeth for beneficiaries age 21 years and older will require PPR. Providers must submit radiographs and supporting documentation to justify the need for the procedure in order for the treatment to be reimbursed by SCDHHS.

Prefabricated Crowns

(Includes all pre-fabricated crowns: stainless steel/esthetic coated stainless steel, resin and porcelain/ceramic).

Placement of a pre-fabricated crown is allowed for children and ID/RD Waiver beneficiaries, once per 36 months, per patient, per tooth without prior authorization. No other restoration on that tooth is compensable during that period. Any additional placements outside of policy will require prior authorization.

The following clinical criteria must be followed for placement of a prefabricated crown:

- Primary teeth (anterior and posterior):
 - Tooth is expected to have more than 12 months of life prior to exfoliation, based on the child's eruption pattern, and
 - Tooth needs an extensive restoration when other restorative materials have a poor prognosis and the restoration is due to any of the following:

- › Substantial decay or trauma
- › Cervical decalcification and/or developmental defects
- › Following pulpal therapy
- Permanent teeth (anterior, bicuspid, molar):
 - Tooth needs an extensive restoration when other restorative materials have a poor prognosis and the restoration is due to any of the following:
 - › Substantial decay or trauma
 - › Cervical decalcification and/or developmental defects
 - › Following pulpal therapy

Prefabricated crowns DO NOT meet the clinical criteria and will not be allowed for reimbursement if:

- Tooth has sub-osseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- PRIMARY tooth root is surrounded by severe pathologic destruction of bone.
- PERMANENT tooth apex is surrounded by untreated pathologic destruction of bone.
- Crown is being planned to alter vertical dimension.
- Crown is used as a temporizing treatment while a permanent restoration is being fabricated.

It is the provider's responsibility to use clinical and professional judgement when planning extensive treatment and multiple crown placements, evaluating the patient's needs, risk for developing tooth decay, health history, and their physical and mental ability to support the extensive treatment.

Documentation Required

Please refer to Section 6: Reporting/ Documentation of this manual for general treatment record keeping requirements. Proper documentation must be maintained in patient's records and must include the following:

- A detailed narrative demonstrating Medical Necessity, and
- Appropriate pre-treatment diagnostic images such as:
 - Radiographs (bitewings, periapicals or panorex) that clearly show the affected tooth/teeth with decay or trauma.

Note: Intraoral photographs may be allowed if the patient’s physical and/or mental status prohibits the provider from obtaining diagnostic radiographs. A detailed narrative with justification of sufficient efforts taken to obtain radiographs must be documented in the patient’s records.

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

Benefits Limitations

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2140	Amalgam - one surface, Primary or permanent	Child	0-20	Teeth 1-32; A-T	One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+		One of (D2140, D2330, D2391) per 36 month(s) per patient, per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2150	Amalgam - two surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T	One of (D2150, D2331, D2392) per 36 month(s) per provider or location per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+		One of (D2150, D2331, D2392) per 36 month(s) per patient, per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2160	Amalgam - three surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2160, D2332, D2393) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2161	Amalgam - four or more surfaces, primary or permanent	Child	0-20	Teeth 1-32; A-T	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2161, D2335, D2394) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2330	Resin-based composite - one surface, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R	One of (D2140, D2330, D2391) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2140, D2330, D2391) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2331	Resin-based composite - two surfaces, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R	One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2150, D2331, D2392) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2332	Resin-based composite - three surfaces, anterior	Child	0-20	Teeth 6-11; 22-27; C-H; M-R	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2160, D2332, D2393) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Child	0-20	Teeth 6-11; 22-27; C-H; M-R	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+		One of (D2161, D2335, D2394) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2390	Resin based composite crown-anterior	Child	0-20	Teeth 6-11, 22-27, C-H, M-R	One (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2391	Resin-based composite - one surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T	One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2140, D2330, D2391) per 36 month(s) per provider or location per tooth, per surface	No	No
		Adult	21+	One of (D2140, D2330, D2391) per 36 month(s) per patient per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No	
D2392	Resin-based composite - two surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T	One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2150, D2331, D2392) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+	One of (D2150, D2331, D2392) per 36 month(s) per patient, per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No	
D2393	Resin-based composite - three surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T	One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2160, D2332, D2393) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+	One of (D2160, D2332, D2393) per 36 month(s) per patient, per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No	
D2394	Resin-based composite – four or more surface, posterior	Child	0-20	Teeth 1-5; 12-21; 28-32; A-B; I-L; S-T	One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		ID/RD Waiver	21+		One of (D2161, D2335, D2394) per 36 month(s) per provider or location, per tooth, per surface	No	No
		Adult	21+	One of (D2161, D2335, D2394) per 36 month(s) per patient, per tooth, per surface	No - Permanent teeth Yes - Retained Primary	No	

Restorative							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Child	0-20	Teeth C-H, M-R	One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2930	Prefabricated stainless steel crown - primary tooth	Child	0-20	Teeth A-T	One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2931	Prefabricated stainless steel crown - permanent tooth	Child	0-20	Teeth 1-32	One of (D2390, D2931, D2932) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2931, D2932) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2932	Prefabricated resin crown	Child	0-20	Teeth 1-32, A-T	One of (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2929, D2930, D2931, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	Child	0-20	Teeth C-H, M-R	One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2390, D2929, D2930, D2932, D2934) per 36 months per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2950	Core buildup, including any pins when required	Child	0-20	Teeth 1-32	One of (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		ID/RD Waiver	21+		One of (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2951	Pin retention - per tooth, in addition to restoration	Child	0-20	Teeth 1-32	One (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		ID/RD Waiver	21+		One (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		Adult	21+	Not a covered service			
D2954	Prefabricated post and core in addition to crown	Child	0-20	Teeth 1-32	One (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		ID/RD Waiver	21+		One (D2950, D2951, D2954) per lifetime per patient per tooth	No	No
		Adult	21+	Not a covered service			

Endodontic Services

Criteria

Reimbursement fee for the endodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: extirpation treatment, shaping and enlarging the canals, temporary fillings, filling and obturation of root canals; progress radiographs and a completed fill radiograph; supplies, materials, trays, equipment; topical/local anesthesia and post-operative care up to 30 days from the date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Payment for conventional root canal treatment is limited to treatment of permanent teeth. PPR is required for conventional root canal treatment of permanent teeth. Multistage procedures are reported and may be reimbursed upon completion. The completion date for endodontic treatment is the date the canals are permanently filled.

Pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

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 clinical criteria:
 - Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
 - Fill must be properly condensed/obtured. Filling material does not extend excessively beyond the apex.
 - The canal(s) must be completely filled apically and laterally.

In cases where the root canal filling does not meet SCDHHS' treatment standards, SCDHHS can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review.

- Root Canal therapy will not meet criteria if:
 - Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
 - The general oral condition does not justify root canal therapy due to loss of arch integrity.
 - Root canal therapy is for third molars, unless they are an abutment for a partial denture.
 - Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g., Sargenti filling material) is used.

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation for claim review as follows:

- Detailed narrative of Medical Necessity, and
- Sufficient and appropriate pre-treatment radiographs clearly showing the pathology of the affected tooth/teeth, and
- A dated post-operative radiograph clearly showing treatment completion as defined in the “Criteria” section of this manual.

Benefit Limitations

Endodontics							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D3220	Therapeutic pulpotomy (excluding final restoration)	Child	0-20	Teeth 2-15, 18-31, A-T	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with one of (D3310, D3320, or D3330) on the same tooth, on the same day.	No	No
		ID/RD Waiver	21+	Teeth 2-15, 18-31, A-T	One D3220 per lifetime per patient per tooth. Not allowed in conjunction with one of (D3310, D3320, or D3330) on the same tooth, on the same day.	No	No
		Adult	21+	Not a covered service			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Child	0-20	Teeth 6-11, 22-27	One D3310 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		ID/RD Waiver	21+	Teeth 6-11, 22-27	One D3310 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		Adult	21+	Not a covered service			

Endodontics							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Child	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	One D3320 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		ID/RD Waiver	21+	Teeth 4, 5, 12, 13, 20, 21, 28, 29	One D3320 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		Adult	21+	<i>Not a covered service</i>			
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Child	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	One D3330 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		ID/RD Waiver	21+	Teeth 2, 3, 14, 15, 18, 19, 30, 31	One D3330 per lifetime per patient per tooth. Not allowed in conjunction with D3220 on the same tooth on the same day.	Yes	No
		Adult	21+	<i>Not a covered service</i>			

Prosthodontic Removable Services

Criteria

Reimbursement fee for the prosthodontic procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: impressions, try-in appointments, delivery; materials, supplies, trays, equipment, topical or local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary’s representative.

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

Provision for removable prostheses must meet the following clinical criteria:

- Full Dentures:
 - As an initial placement:
 - › The masticatory function must be impaired.

Note: A denture is determined to be an initial placement if the Beneficiary has never worn a prosthesis. Initial placement does not refer to the first time a Beneficiary is seen and treated by a given Provider.

- As a replacement of an existing prostheses:
 - › The existing prosthesis is unserviceable, and
 - › The evidence submitted indicates that the masticatory insufficiencies are likely to impair the general health of the member, and
 - › The existing prosthesis is at least three years old.

- Partial Dentures:

- As an initial placement:
 - › The masticatory function must be impaired, and

Note: A denture is determined to be an initial placement if the Beneficiary has never worn a prosthesis. Initial placement does not refer to the first time a Beneficiary is seen and treated by a given Provider.

- › Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone, and
 - › Partial dentures are covered only for beneficiaries with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- For replacement of an existing prostheses:
 - › The existing prosthesis is unserviceable, and
 - › The evidence submitted indicates that the masticatory insufficiencies are likely to impair the general health of the member, and
 - › The existing prosthesis is at least three years old, and
 - › Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone, and
 - › The replacement teeth should be anatomically full sized teeth.

As part of any removable prosthetic service, dentists are expected to instruct the Beneficiary in the proper care of the prosthesis.

Removable prosthesis will not meet criteria for the following reasons:

- Partial dentures are not a covered benefit when eight or more posterior teeth are in occlusion.
- Partial dentures not allowed for closing a space gap without missing teeth.
- If there is a pre-existing prosthesis which is not at least three 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 Beneficiary cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the Beneficiary has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If repair, relining or rebasing of the patient's present dentures will make them serviceable.
- If a partial denture, less than three 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 Beneficiary. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the partial denture meet functional criteria.
- 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.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances.

- All prosthetic appliances shall be seated 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.
- Beneficiaries must be eligible on that date in order for the denture service to be covered. In addition, there may be coverage for dentures in cases where extractions are performed in conjunction with an authorized denture or final impression while the Beneficiary is still eligible.

A preformed denture with teeth already mounted forming a denture module is not a covered service. Adjustments, relines and/or rebases are non-covered services.

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation for claim review as follows:

- Detailed narrative of Medical Necessity, and
- Pre-operative diagnostic images such as radiographs or CT scan.

Benefit Limitations

Prosthodontics, Removable							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D5110	Complete denture - maxillary	Child	14-20		One D5110 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5110 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5120	Complete denture - mandibular	Child	14-20		One D5120 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5120 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5211	Maxillary partial denture - resin base (including, retentive/clasp materials, rests and teeth)	Child	14-20		One D5211 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5211 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			
D5212	Mandibular partial denture - resin base (including retentive/clasp materials, rests and teeth)	Child	14-20		One D5212 per 60 month(s) per patient	Yes	No
		ID/RD Waiver	21+		One D5212 per 60 month(s) per patient	Yes	No
		Adult	21+	Not a covered service			

Prosthodontics, Removable							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D5511	Repair broken complete denture base, mandibular	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5512	Repair broken complete denture base, maxillary	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5520	Replace missing or broken teeth - complete denture (each tooth)	Child	14-20	Teeth 1-32		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5611	Repair resin partial denture base, mandibular	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5612	Repair resin partial denture base, maxillary	Child	14-20			No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D5640	Replace broken teeth -per tooth (partial denture)	Child	14-20	Teeth 1-32		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			

Dental Surgery (Extractions)

Criteria

Reimbursement fee for the surgical procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/local anesthesia and post-operative care up to 30 days from date of service. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary’s representative.

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

Reimbursement for a tooth extracted within a 12-month timeframe after the placement of a dental sealant, a restoration or endodontic treatment by the same provider or provider location, is subject to payment adjustment based on the initial service.

Provision of a dental extraction must meet **at least one** of the following criteria:

- Tooth is determined to be non-restorable; 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 sub-osseous 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 Beneficiary is such that an alternative treatment plan would be better suited to meet the Beneficiary's needs.
- Tooth is compromising the patient's dental health and/or overall health and development.
- Provider's clinical judgement determines that there is no other alternative treatment option.

SCDHHS will not reimburse for the removal of primary teeth whose exfoliation is imminent.

Documentation Required

Proper documentation must be maintained in patient's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation for claim review as follows:

- A detailed narrative demonstrating Medical Necessity, and
- Appropriate pre-treatment diagnostic images such as: intraoral/extraoral radiographs or CT scan that clearly show the affected tooth and its surrounding hard and soft tissues.

Note: Intraoral photographs may be allowed if the patient's physical and/ or mental status prohibits the provider from obtaining diagnostic radiographs. A detailed narrative with justification of sufficient efforts taken to obtain radiographs must be documented in the patient's records.

Benefit Limitations

Dental Extractions							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D7111	Extraction, coronal remnants - primary tooth	Child	0-20	Teeth A-T; AS-TS		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+	Not a covered service			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Child	0-20	Teeth 1-32; 51-82; A-T; AS-TS		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+		No	No	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Child	0-20	Teeth 1-2; 51-82; A-T; AS-TS		No	No
		ID/RD Waiver	21+			No	No
		Adult	21+			No	No
D7220	Removal of impacted tooth-soft tissue	Child	0-20	Teeth 1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7230	Removal of impacted tooth-partially bony	Child	0-20	1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7240	Removal of impacted tooth-completely bony	Child	0-20	1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	Child	0-20	1-32; 51-82; A-T; AS-TS		Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No
D7250	Removal of residual tooth roots (cutting procedure)	Child	0-20	1-32; 51-82; A-T; AS-TS	Not allowed by same office or provider who performed original extraction.	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No

Adjunctive Services

Criteria

Reimbursement fee for the adjunctive procedure includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: materials, supplies, trays, equipment, topical or local anesthesia. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Claims filed for adjunctive services must also include the procedure code(s) rendered in conjunction with the adjunctive service(s). Adjunctive services will be considered for review and reimbursement only when accompanied by a covered service or by an approved EPSDT service and when the Medical Necessity for the service is established through supporting documentation (refer to documents required and clinical criteria for each specific procedure/procedure category).

Use of sedation for beneficiaries age 21 years and older may be allowable if authorized through PA or PPR ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon. If medically necessary, use of these codes will not count towards a Beneficiary's \$750 annual maximum.

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

Dental Sedation Services in Dental Office

Reimbursement for moderate or deep sedation/general anesthesia administered in dental offices will be limited to only those providers that have a valid dental sedation permit from the State Board of Dentistry, a copy of which is on file with DentaQuest.

All dental sedation services administered in the office must be performed by an authorized provider to assure appropriate monitoring of the beneficiary. The administration of sedation and/or anesthesia by or under the direction of an authorized dental provider shall be performed in accordance with the State laws and regulations, applicable guidelines approved by the authorizing agency that regulates the practice of dentistry in the State, including but not limited to, current American Dental Association "Guidelines for the Use of Sedation and General Anesthesia by Dentists"; and the joint American Academy of Pediatric Dentistry and American Academy of Pediatrics (AAP) Pediatrics "Guidelines for Monitoring and management of pediatric patients before, during and after sedation for diagnostic and therapeutic procedures". The rendering dental provider is solely responsible for the administration and management of sedation and/or anesthesia in the practice of dentistry, including but not limited to, ordering, supplying and prescribing medications used in the sedation procedure, and must determine which of the guidelines, as referenced above, he or she shall operate under, and shall be responsible for complying with the same, as provided above.

Providers must comply with the South Carolina 2014 Dental Sedation Act 222 (South Carolina Code of Laws 40-15-450) requirements for patient's record keeping. SCDHHS also requires that both the

authorized office location and administering provider must be clearly documented in the patient's record. If there is no sedation documentation in the treatment record that meets these requirements for a billed service, then the service is subject to recoupment by SCDHHS.

PPR is required for general anesthesia and IV sedation administered in the dental office. Claims filed for general anesthesia or IV sedation services must also include all the procedure codes for which the sedation services were rendered. Sedation services must be accompanied by a covered service and/or by an approved EPSDT service in order to be considered for review.

General Anesthesia/IV sedation services administered in the dental office will be allowed when ALL of the following criteria are met:

- Required Documentation must be submitted with the claim for PPR, and
- Clinical criteria must include one of the following:
 - Treatment is comprised of extensive or complex oral surgical procedure such as: impacted wisdom teeth, surgical root recovery from maxillary antrum, surgical exposure of impacted or unerupted cuspids, radical excision of lesions in excess of 1.25 cm, or
 - Beneficiary has a medical condition(s) which requires monitoring (e.g., cardiac problems, severe hypertension), or
 - Beneficiary has an underlying hazardous medical condition or mental or physical disability which would render the Beneficiary non-compliant during treatment, or
 - Beneficiary has a documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective, or
 - Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures and the documentation justifies that in-office general/IV sedation is appropriate and is not sought solely based on reducing, avoiding or controlling apprehension, or on Provider's or Beneficiary's convenience, or
 - Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates that in-office general anesthesia/IV sedation is appropriate.

Utilization of Ambulatory Surgical Center (ASC) or Outpatient Operating Room (OR)

Planned, non-emergent dental services delivered in an outpatient OR, or ASC must be prior authorized. Authorizations requests must include the procedure codes that will be rendered, as well as the appropriate procedure code that identifies the utilization of the OR/ASC. The Authorization request for the use of the ASC/OR facility will be considered for review only when accompanied by a

covered service or by an approved EPSDT service and must be submitted with appropriate documentation no less than 15 days prior to the date of treatment.

Services delivered in an OR, or ASC will be authorized when ALL of the following criteria are met:

- Procedure code that identifies the utilization of the ASC/OR facility, and
- Required Documentation must be submitted with the authorization request, and
- Clinical Criteria which must include one of the following:
 - Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and outpatient setting is not sought solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Beneficiary convenience.
 - Beneficiaries requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) Class III and ASA Class IV (Class III — Beneficiaries with uncontrolled disease or significant systemic disease, for recent MI, recent stroke, chest pain, etc.; Class IV — Beneficiaries with severe systemic disease that is a constant threat to life).
 - Medically compromised Beneficiaries whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
 - Beneficiaries requiring extensive dental procedures with a medical history or complex medical condition that renders in-office treatment not medically appropriate.
 - Beneficiaries 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 outpatient setting is appropriate.

Behavioral Management

Behavioral Management services will be approved when ALL of the following criteria are met:

- Required documentation must be submitted with the claim for PPR, and
- Clinical criteria for the use of behavior management must include ALL of the following:

- Child Beneficiary presenting with disabilities and/or special health care needs or Beneficiary is a member of the ID/RD Waiver program and need for behavior management is documented in the patient’s dental record, and
- Documentation supplied for adjudication of the claim and recorded in the dental record is unique to that visit and includes a description of the known condition of the patient and additional time requirement to provide treatment.

The Behavioral Management services are not allowed in conjunction with sedation services (Nitrous Oxide, deep sedation/general anesthesia, IV or non-IV Moderate sedation).

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation. Procedures that require PA must meet the Medical Necessity and require submission of proper documentation. Services that require review must be submitted with the following documentation:

- Detailed narrative describing Medical Necessity of the services to be delivered in conjunction with the adjunctive service, and
- Necessary documentation as required for each procedure/ procedure category to support the Medical Necessity.

Benefits Limitation

Adjunctive General Services							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D9222	Deep sedation/ general anesthesia - first 15 minutes	Child	0-20		Allowed 1 unit of D9222 per 1 day(s) per patient. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920. <i>For adult Beneficiaries, this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+			Yes	No

Adjunctive General Services							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D9223	Deep sedation/ general anesthesia - each subsequent 15-minute increment	Child	0-20		Allowed 1 unit of D9223 per 1 day(s) per patient. Allowed with D9222 only. Not allowed in conjunction with D9230, D9239, D9243, D9248 or D9920.	Yes	No
		ID/RD Waiver	21+		<i>For adult Beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		Adult	21+			Yes	No
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	Child	0-20		One D9230 per 1 day(s) per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243 or D9920.	No	No
		ID/RD Waiver	21+		<i>For adult Beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	No	No
		Adult	21+			Yes	No
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	Child	0-20		Allowed 1 unit of D9239 per 1 day(s) per patient. Not allowed in conjunction with D9222. D9223, D9230, D9248 or D9920.	Yes	No
		ID/RD Waiver	21+		<i>For adult Beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		Adult	21+			Yes	No
D9243	Intravenous moderate (conscious) sedation/ analgesia - each subsequent 15-minute increment	Child	0-20		Allowed 1 unit of D9243 per 1 day(s) per patient. Allowed with D9239 only. Not allowed in conjunction with D9230, D9222, D9223, D9248 or D9920.	Yes	No
		ID/RD Waiver	21+		<i>For adult Beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	Yes	No
		Adult	21+			Yes	No
D9248	Non-intravenous moderate (conscious) sedation	Child	0-20		One of D9248 per 1 day(s) per patient. Not allowed in conjunction with D9222, D9223, D9239, D9243 or D9920.	No	No
		ID/RD Waiver	21+		<i>For Adult Beneficiaries this is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	No	No
		Adult	21+			Yes	No

Adjunctive General Services							
Code	Description	Beneficiary Subgroup	Benefit Limitations			Pre-Payment Review Required	Prior Authorization
			Age (Years)	Teeth/Quad/Arch	Frequency/Timespan		
D9420	Hospital or ambulatory surgical center call	Child	0-20		One D9420 per 1 day(s) per patient. May be billed when rendering prior approved treatment in an outpatient operating room or ASC. SCDHHS prohibits the billing of beneficiaries to schedule appointments or to hold appointment blocks prior to treatment in a hospital or ambulatory center setting. <i>For adult Beneficiaries is allowed ONLY when medically necessary for treatment of an adult with a special needs diagnosis or ONLY when medically necessary for treatment by an oral surgeon.</i>	No	Yes
		ID/RD Waiver	21+			No	Yes
		Adult	21+			No	Yes
D9920	Behavior management, by report	Child	0-20		One D9920 per 1 day(s) per patient. Documentation in the patient record must be unique to that visit and must include a description of the known condition of the patient and additional time to provide treatment. Not allowed with D9222, D9223, D9230, D9239, D9243, D9248 or D9420.	Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+	Not a covered service			
D9999	Unspecified adjunctive procedure, by report	Child	0-20			Yes	No
		ID/RD Waiver	21+			Yes	No
		Adult	21+	Not a covered service			

Services for Emergency or Repair of Traumatic Injury

Criteria

Reimbursement fee for the Oral and Maxillofacial Surgical Procedures for emergency or repair of traumatic injury includes any items or related activities/services that are necessary to accomplish the procedure, which may include but are not limited to: supplies, materials, trays, surgical trays, equipment, topical/local anesthesia and post-operative care up to 30 days from date of service.

None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary’s representative. PPR is required for Oral and Maxillofacial Surgical Procedures for emergency or repair of traumatic injury, except the medical exam procedure codes.

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

Tooth Reimplantation

Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth (D7270) is allowed only for permanent teeth.

Exposure of an Unerupted Tooth

Exposure of unerupted tooth (D7280) — is allowed only two per 1 day(s) per patient for permanent teeth only. Not allowed with extraction codes.

Biopsy

Biopsy of oral tissue (code D7285 and D7286) is not billable with another surgical procedure that is part of the same procedure.

Excision of Soft Tissue Lesions

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

Removal of Foreign body

Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue (D7530) — is allowed only one per 1 day(s) per patient.

Ostectomy/Sequestrectomy

Partial Ostectomy/Sequestrectomy per quadrant (D7550) — not allowed to be billed for treatment of dry socket.

Wound Repair

Small or large wound repair sutures (D7910, D7911 or D7912) — excludes closure of surgical incision.

Documentation Required

Proper documentation must be maintained in patient's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Procedures that require PPR can be rendered before determination of Medical Necessity but require submission of proper documentation with the claim form. Claims must be submitted with the following documentation:

- Detailed narrative of Medical Necessity and any additional documentation that would support the Medical Necessity, and

- Pre-operative diagnostic images such as radiographs or CT, and
- Pathology report or intraoral photographs when applicable.

Benefit Limitations

Oral and Maxillofacial Surgical Services					
Procedure Codes	Eligible Beneficiaries	Age (years)	Benefit Description	Pre-Payment Review Required	Prior Authorization Required
Dental Services					
D7270, D7280, D7285, D7286, D7410, D7411, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7465, D7510, D7520, D7530, D7550, D7670, D7671, D7770, D7771, D7910, D7911, D7912	Child	0-20	When Medically necessary for emergency and/or repair of traumatic injury.	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+	<i>Not a covered service</i>		
Medical Services					
11900; 12011-12015; 12020; 12051-12055; 13131-13133; 13151-13153; 15120; 15121; 20670; 20680; 20694; 20900; 20902; 21025-21044; 21046-21048; 21050-21070; 21076; 21081; 21085; 21100-21116; 21209-21243; 21310-21340; 21344-21345; 21356; 21360; 21390; 21400-21407; 21421; 21440-21465; 21480-21490; 21497; 29800; 29804; 30580; 30901-30906; 31000; 31020; 31030-31040; 31500; 31603; 31605; 40490-40530; 40650-40761; 40800; 40801; 40808-40819; 40830; 40831; 41000-41009; 41015-41018; 41100-41120; 41250-41252; 41800-41806; 41822-41850; 41874; 42100-42106; 42120; 42140; 42180; 42182; 42200-42225; 42235; 42260; 42300-42340; 42408; 42409; 42440; 42450; 42500; 42505; 42550; 42650; 42720; 42725; 64722; 64774; 64788; 67930; 67935; 88160; 88300-88312; 99201-99205; 99211-99223; 99231-99239; 99241-99245; 99251-99255; 99281-99285; 99291; 99292; 99304-99310; 99324-99328; 99334-99337; 99341-99350; 99441	Child	0-20	When Medically necessary for emergency and/or repair of traumatic injury; medical services must be rendered by Oral Surgeons only. Medical exam procedure codes do not require PPR.	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+		Yes	No

Services for Exceptional Medical Conditions

Criteria

Medicaid Beneficiaries eligible for dental services may receive medically necessary dental services delivered during treatment or in preparation for the following exceptional medical conditions:

- Organ transplants
- Oncology
- Radiation of the head and/or neck for cancer treatment
- Chemotherapy for cancer treatment
- Total joint replacement
- Heart valve replacement

The treating medical doctor or specialist must request the dental procedure(s) to be performed. The Dental Provider must determine Medical Necessity for the course of treatment for the requested procedure(s).

Documentation Required

All claims submitted for the dental services in preparation for or during treatment of the exceptional medical conditions listed above are subject to PPR with submission of appropriate documentation from both dental provider and the referring medical provider; PA is optional.

Proper documentation must be maintained in patient's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Claims must be submitted with the following documentation:

- Detailed narrative of Medical Necessity and any additional documentation that would support the Medical Necessity, and
- Treating medical doctor or specialist request and/or documentation of medical condition diagnosis and treatment plan, and
- Pre-operative diagnostic images such as radiographs or CT scan, and
- Pathology report, post-operative radiographs or intraoral photographs when applicable.

Benefit Limitations

Services for Exceptional Medical Conditions					
Procedure Code Set	Eligible Beneficiaries	Age (years)	Benefit Description	Pre-Payment Review Required	Prior Authorization Required
Dental Services					
CDT Dental Codes	Child	0-20	When medically necessary dental services delivered in preparation for, or during the course of treatment for: <ul style="list-style-type: none"> • Organ transplants. • Radiation of the head or neck for cancer treatment. • Chemotherapy for cancer treatment. • Total joint replacement. • Heart valve replacement. 	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+		Yes	No
Medical Services					
CPT Medical Codes (Diagnostic and Head and Neck Surgical Procedures for Musculoskeletal System)	Child	0-20	When medically necessary dental services delivered in preparation for, or during the course of treatment for: <ul style="list-style-type: none"> • Organ transplants. • Radiation of the head or neck for cancer treatment. • Chemotherapy for cancer treatment. • Total joint replacement. • Heart valve replacement. 	Yes	No
	ID/RD Waiver	21+		Yes	No
	Adult	21+		Medical services must be rendered by Oral Surgeons only. Medical exam procedure codes do not require PPR.	Yes

Non-State Plan Covered Services — EPSDT Services

Criteria

Children age 0–20, through the month of the 21st birthday are eligible for medically necessary EPSDT services defined as:

Medically necessary dental services delivered outside of the SCDHHS established policy or not otherwise listed as a State Plan covered service. All EPSDT services require PA, with the exception when the service is delivered as an emergency or service is part of the Initial Dental Encounter for a foster child (please refer to the Prior Authorization section of this manual).

Initial Dental Encounter for Foster Children upon entry in Foster Care Program

The DSS Foster Care Program requirements include an initial dental encounter within 30 days upon a child’s entry into the program. Medicaid eligible children entering the Foster Care Program are eligible to receive this initial dental encounter under the EPSDT benefit. The initial dental encounter

includes a comprehensive oral evaluation, prophylaxis, fluoride application and any medically necessary diagnostic procedures, regardless of the child’s prior service history. To bypass the PA required for the EPSDT services, providers who will render the initial dental encounter for foster care members, should follow the process detailed in Filing Claims section 7 of this manual.

This policy applies only to the services included in the initial dental encounter for foster care members. A copy of the DSS Health Encounter Form must be maintained in the child’s dental records. Providers must follow the SCDHHS established policies for all other medically necessary services. Providers must follow the Dental Periodicity Schedule for subsequent visits and examinations accessible at: <https://msp.scdhhs.gov/epsdt/site-page/periodicity-schedule>.

Documentation Required

Proper documentation must be maintained in patient’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record keeping requirements.

Both PAs and claims submitted for EPSDT services must include the following documentation:

- Detailed narrative of Medical Necessity and any additional documentation that would support the Medical Necessity, and
- pre-operative diagnostic images such as radiographs or CT, and
- Pathology report, post-operative radiographs or intraoral photographs when applicable.

Benefit Limitations

Non-State Plan Covered Services — EPSDT Services					
Procedure Codes	Eligible Beneficiaries	Age (years)	Benefit Description	Pre-Payment Review Required	Prior Authorization Required
EPSDT Dental Services					
CDT Dental Codes	Child	0-20	Medically necessary dental services delivered outside of the SCDHHS established policy or not otherwise listed as a State Plan covered service.	No	Yes
	ID/RD Waiver	21+	<i>Not a covered service</i>		
	Adult	21+	<i>Not a covered service</i>		
EPSDT Medical Services					
CPT Medical Codes	Child	0-20	Medically necessary head and neck diagnostic and surgical medical procedures delivered outside of the SCDHHS established policy or not otherwise listed as a State Plan covered service. These services are rendered by Oral Surgeons only.	No	Yes
	ID/RD Waiver	21+	<i>Not a covered service</i>		
	Adult	21+	<i>Not a covered service</i>		